

MEDICARE HMO REGULATION AND QUALITY

OFFICIAL

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
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(III)

MEDICARE HMO REGULATION AND QUALITY

THURSDAY, MARCH 6, 1997

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 1:06 p.m., in room B-318, Rayburn House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisories announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE

CONTACT: (202) 225-3943

February 25, 1997

No. HL-4

Thomas Announces Hearing on Medicare HMO Regulation and Quality

Congressman Bill Thomas (R-CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on consumer protections and quality standards for Medicare beneficiaries. The hearing will take place on Thursday, March 6, 1997, in 1310 Longworth House Office Building, beginning at 1:00 p.m.

In view of the limited time available to hear witnesses, oral testimony will be heard from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The percentage of Medicare beneficiaries choosing to enroll in Medicare risk HMOs has nearly tripled since 1991, and the Congressional Budget Office predicts that more than one third of beneficiaries will be enrolled in HMOs by the year 2007. As this trend continues, there has been an increasing focus on quality and consumer protections in the Medicare risk contracting program.

The Medicare program currently has significant safeguards in place to ensure that beneficiaries enrolled in risk plans receive quality health care. For example, Medicare managed care plan enrollees have the right to appeal any benefit decision by a provider or a plan, including the length of time authorized for a hospital stay. In addition, beneficiaries have the right to an expedited review by a Peer Review Organization if they feel they may be discharged prematurely from a hospital.

The Health Care Financing Administration (HCFA) has undertaken a number of recent actions intended to provide Medicare managed care enrollees with additional protections and with information about health plan quality so that beneficiaries can make more informed choices about the risk plans available to them.

President Clinton's fiscal year 1998 budget proposal includes a number of provisions granting the Administrator of HCFA greater authority over Medicare managed care and Medigap plans. These proposals would allow HCFA to establish an annual coordinated open enrollment period for Medicare managed care and Medigap plans, provide beneficiaries with comparative information on plan options, repeal the outdated 50/50 rule, and restrict the additional benefits that may be offered by Medicare managed care plans to standardized packages prescribed by HCFA.

In addition, many States recently have adopted managed care consumer protection laws and the largest association representing the managed care industry has announced a series of voluntary initiatives aimed at ensuring that consumer protections are in place in the private market.

In announcing the hearing, Chairman Thomas stated: "In response to public concerns about managed care, HCFA has taken the initiative in its oversight of private

Medicare plans. These initiatives have been well-reasoned, and I look forward to learning more about the Administration's response to some of the warning signs that have been raised about managed care."

FOCUS OF THE HEARING:

The hearing will focus on HCFA's recent actions to improve consumer protections and quality assessment in the Medicare risk program. It also will focus on provisions in President Clinton's fiscal year 1998 budget proposal relating to quality and consumer protection in the Medicare program. The Administration's efforts will be assessed in light of State and private sector efforts to improve quality in managed care plans.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement and a 3.5-inch diskette in WordPerfect or ASCII format, with their address and date of hearing noted, by the close of business, Thursday, March 20, 1997, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments. At the same time written statements are submitted to the Committee, witnesses are now requested to submit their statements on a 3.5-inch diskette in WordPerfect or ASCII format.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at '[HTTP://WWW.HOUSE.GOV/WAYS_MEANS/](http://WWW.HOUSE.GOV/WAYS_MEANS/)'.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-225-1904 TTD/TTY in advance of the event (four business days' notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

**NOTICE—CHANGE IN ROOM
ADVISORY
FROM THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH**

FOR IMMEDIATE RELEASE

CONTACT: (202) 225-3943

March 5, 1997

No. HL-4-Revised

**Room Change for Subcommittee Hearing on
Thursday, March 6, 1997,
on Medicare HMO Regulation and Quality**

Congressman Bill Thomas, (R-CA), Chairman of the Subcommittee on Health, Committee on Ways and Means, today announced that the Subcommittee hearing on Medicare HMO Regulation and Quality previously scheduled for Thursday, March 6, 1997, at 1:00 p.m., in 1310 Longworth House Office Building, will be held instead in B-318 Rayburn House Office Building.

All other details for the hearing remain the same. (See Subcommittee press release No. HL-4, dated February 25, 1997.)

Mr. ENSIGN [presiding]. The Subcommittee will come to order.

I want to welcome everyone to today's hearing on Medicare oversight of managed care plans. I will be sitting in for Chairman Thomas and will be reading his opening statement this morning.

The Subcommittee will examine recent efforts by HCFA, the Health Care Finance Administration, to improve consumer protections and quality standards in the Medicare managed care program. We will also focus on provisions in President Clinton's fiscal year 1998 budget proposal relating to oversight of Medicare managed care plans.

The percentage of Medicare beneficiaries choosing to enroll in private managed care plans has nearly tripled since 1991, and the Congressional Budget Office estimates that more than one-third of the beneficiaries will be enrolled in HMOs by the year 2007. As managed care becomes an increasingly important part of the Medicare Program, it is critical that HCFA uses state-of-the-art quality measures and purchasing methods to assure that health plans deliver the best possible value for beneficiaries and Medicare.

At the same time, we must ensure that Medicare's consumer protection standards are flexible enough to keep pace with advances in medical technology, to adapt the rapidly changing health care

market, and to allow private plans to be innovative providers of care.

Nearly one-half of all private HMOs participate in the Medicare managed care program. As we expand the types of managed care choices available to Medicare beneficiaries, even more private health plans will be participating in Medicare. Therefore, Medicare oversight policy will have a significant impact on the practices of health plans in both the public and private health care markets.

We learned, for example, with the implementation of DRG, the Diagnostic Related Groups payment reforms in 1983, what a powerful influence Medicare can have on the practices of hospitals and providers. With the incentives from DRGs, hospitals and doctors became more efficient for all patients. Similarly, HCFA's efforts to improve quality and customer protection for Medicare beneficiaries can have an impact far beyond the Medicare Program. By leveraging its substantial purchasing power, Medicare can be an engine for improving the private health care market, without resorting to disruptive overregulation.

I look forward to today's testimony, and I recognize the Ranking Member, Mr. Stark, for an opening statement.

Mr. STARK. Thank you, Mr. Chairman. I appreciate your holding this hearing. Quality standards and consumer protections in managed care plans, Medicare managed care plans, in particular, are probably two of the most important things we can do for Medicare beneficiaries.

At your managed care hearing last week, it was demonstrated that managed care plans come in many shapes and sizes, and they can vary dramatically in terms of benefits offered, the quality provided, medical loss ratios, and compensations of chief executives. You have well-established plans like Kaiser Permanente in my district—not necessarily all across the country—that has every reason to be proud of their record. There are other plans we read about every day in the press that do not share that same reputation.

I have introduced—and I think maybe my staff passed out, in a modest move to my colleagues on the Subcommittee, a summary of a bill I have introduced—H.R. 337. I am not suggesting to you that I have any overly optimistic hopes that I will see this enacted into law, but I believe I can tell you and my colleagues that just about every consumer protection that any other bill has suggested is in here. I only use it for you as a reference point for today's witnesses if you are concerned about immunization requirements or coordination of open enrollment. All of the topics are covered, and you may or may not agree with how we resolve them, but they are issues that will come up before us in terms of regulation and/or protecting our consumers. I offer H.R. 337 as a guideline or at least an index to the issues before us.

I want to congratulate the administration for a change by moving forward on a number of issues, some that are in my bill, things like better appeals and grievance processes that will apply to all States, as I understand, won't they, Bruce, not just New York?

Mr. VLADECK. All States.

Mr. STARK. Good. All right. That is progress. [Laughter.]

Although that is a good start—

Mr. VLADECK. We may find an exception for New York.

Mr. STARK [continuing]. It is not nearly enough.

I am concerned by the Inspector General's recent reports with a number of alarming statistics concerning appeals and grievance procedures. The reports point out that beneficiaries are not well informed of their appeal rights at the time the services or payment are denied—they may learn about it a week or two later, or their heirs may learn about it at the mortuary. The Inspector General also found that HMOs are incorrectly categorizing appeal and grievance issues and that the marketing materials some HMOs are using contain incorrect or incomplete information on appeal and grievance rights. I hope we can take some steps in correcting or improving the lot of beneficiaries.

I look forward to hearing from Dr. Vladeck and the rest of today's witnesses.

Thank you.

Mr. ENSIGN. I would like to welcome the first panel, Hon. Bruce Vladeck, and we look forward to hearing your testimony.

STATEMENT OF HON. BRUCE C. VLADECK, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. VLADECK. Thank you very much, Mr. Chairman and Members of the Subcommittee. I am pleased to be here today. I am particularly pleased to have found the hearing, and I apologize for arriving somewhat late, as we wandered through the tunnels in the process. But, more importantly, I am pleased to be here to describe how we at the Health Care Financing Administration are working to make sure that Medicare beneficiaries enrolled in managed care plans receive high-quality care, just as we are obligated to ensure that beneficiaries in the fee-for-service sector receive high-quality care.

We are working to become more adept at meeting our goals that we have described and of being an effective beneficiary-centered purchaser of care. Since we are the Nation's largest purchaser not only of managed care services but of a variety of health care services, we want to effectively use the forces of the market to obtain the best value for all of our beneficiaries.

In consultation with the staff of the Subcommittee, I have not addressed issues of managed care payment reforms in my prepared testimony today, but I would be happy to answer any questions Members might have subsequently.

Let me very quickly make a few points from my statement. Obviously, Medicare managed care is growing very quickly. As of January 1, almost 5 million beneficiaries were enrolled in 350 managed care plans with which we had contracts under the Medicare Program. We have been running an annual growth rate of about 30 percent fairly consistently for the last 4 years.

We believe this growth in enrollment is continuing because Medicare HMOs continue to offer attractive packages of benefits to beneficiaries. Reduction in paperwork, the promise of an organized system of care, and the "word of mouth" in many of the communities about the plans continues to be quite favorable.

Already, under current law, our beneficiaries who are seeking or contemplating enrolling in managed care plans have a wide variety of protections. They are entitled to clear and accurate information

about their choices, and plans may not undertake health screening or limitations on preexisting conditions. There are also requirements that all plans provide access to medically necessary and appropriate care. As Mr. Stark suggested, there are already in place procedures to resolve grievances and the availability of a neutral third party for appeal of grievance decisions, although we are seeking to improve those rules. There is both internal—that is to say, within the plan—and external review of the quality of care provided to beneficiaries in Medicare HMOs. There are specific protections from the risk of discontinuous or inappropriate care that could result from the financial instability of a plan. And, there are very explicit limitations on beneficiaries' out-of-pocket expenses, both the premiums cost sharing and the prohibitions against balance billing.

In the last couple of years, we have been working to strengthen these beneficiary protections with a set of administrative actions and in the development of some legislative proposals. We are working to improve the appeals and grievance procedures and expect to be in the formal rulemaking process in that regard in the very near future. These improved procedures will provide for expedited appeals in certain time-sensitive situations, shorten timeframes for all reviews involving denials of service or terminations of coverage, and improve accountability on the operations of plans' appeals and grievance systems.

Recently, we reminded all Medicare HMOs that under the statute, contracting plans must make all covered services available and accessible to each beneficiary, as determined by the individual's medical condition; therefore, any prohibition or restriction on the ability of physicians to communicate treatment options to beneficiaries is forbidden.

We have communicated directly with all of the plans about the specific concerns that have been raised about treatment for breast cancer and particularly the issue of subsequent breast cancer surgery hospitalization. And as was quite appropriately pointed out to us by the Chairman the last time I was here, the issues raised here apply not only to managed care but also in the fee-for-service sector as well. We have reinforced that message with communications to our contractors on the fee-for-service side as well.

We have put in place new rules, effective this past January 1, implementing legislation that first was put together in this Subcommittee. This legislation requires managed care plans with Medicare and Medicaid contracts to disclose information about physician incentive payment plans and to limit the financial risk to which physicians participating in such plans are exposed.

We have undertaken administratively, and we are supporting in the President's budget bill as well, clarification of our policy that emergency services are covered, to the extent that a prudent layperson could be reasonably expected to believe there was a risk of serious harm to the patient. We have reminded plans of that in writing, but we have proposed to codify that legislatively.

We are very close to the issuance of modified uniform national marketing guidelines. This is something on which we have worked very closely, both with the industry and with the consumer community, to make sure that beneficiaries receive or are exposed to mar-

keting material that is helpful to them in making informed decisions.

We continue to work to refine and improve the published material that we make directly available to beneficiaries about the Medicare Program in general and about HMO choices in particular. Mr. Chairman, we are particularly proud of the expanded annual distribution of the Medicare Handbook to all our beneficiaries which will not only improve the information about HMOs but clarify the information about the availability of Medicare Select policies.

In the President's budget bill we have proposed that comprehensive comparative information on all plan options, including supplemental or Medigap insurance, be provided to Medicare beneficiaries through an annual process funded in each market area by participating plans. In the interim, with our very limited resources, we are making such comparative information available on the Internet and to organizations which provide beneficiary counseling, including insurance counseling, grantees, in each of the 50 States.

In Denver, as part of our competitive pricing demonstration, we will be testing an expanded and more sophisticated range of education and information resources for beneficiaries, including not only new formats for the printed materials, but in-person seminars and a 1-800 call center, all operated by an HCFA-sponsored, independent third party.

Another small-scale experiment we have undertaken began this past October when we opened a convenient, one-stop personal service facility entitled "Your Medicare Center" in a shopping mall in Center City, Philadelphia. It is a test site for direct beneficiary services and beneficiary contacts. We will be collecting data on the kinds of questions people have and the ways in which our staff has been able to resolve them.

Now, we have also been working with our partners in the purchasing community, the managed care industry, to accelerate the development of outcome measures. As I am sure you know, as of January 1, 1997, we're requiring Medicare managed care plans to use the Health Plan Employer Data and Information Set, HEDIS Version 3.0, to report on their performance, particularly on the eight components that have been added to that data set that are specific to Medicare and Medicaid populations.

In conjunction with the Agency for Health Care Policy Research in HHS, the Department of Defense, the Office of Personnel Management, and a range of private employers, we have joined in the creation of the Foundation for Accountability, which has developed and is now testing a set of quality measures for the management and treatment of depression, breast cancers, and diabetes. Also, in conjunction with the Agency for Health Care Policy and Research, we have worked to design a new survey for managed care beneficiaries, to be called the Consumer Assessment of Health Plan Studies, or CAHPS, which we will use for all Medicare managed care plans this year as well.

Through the Medicare Managed Care Quality Improvement Project, we have refocused our PROs on evaluating how well ambulatory care is being provided, both in managed care and in fee-for-service settings.

Under our Choices Demonstration Program, we will be developing and testing additional quality and outcomes measures, and state-of-the-art risk adjustment measurement systems, as ways of seeing the extent to which we can use encounter data, data that is characterizing all services provided to all enrollees, to monitor the quality of services on a continuing basis.

Recognizing that knowledge is power, in our legislative proposals we seek to further empower beneficiaries by giving them more choices and strengthening the information dissemination proposal.

I would like to highlight a few elements of the President's 1998 budget plan. We will be, under that proposal, expanding managed care options to include both preferred provider organizations and provider-sponsored organizations. We believe that direct contracts with such alternative managed care plans are critical to expanding managed care to rural areas, and, of course, very much resemble similar proposals that this Subcommittee has supported in the past.

Under the President's new budget, all beneficiaries, not just aged beneficiaries, would have the opportunity to enroll in a managed care Medigap plan when they first become eligible for Medicare. In addition, each year all Medigap and managed care plans will have a common annual, 1 month, coordinated open enrollment period, although the plans, at their discretion, could provide enrollment opportunities throughout the year, and there will be additional mandatory enrollment opportunities under other circumstances.

We would require Medigap plans to operate under the same rules as Medicare managed care plans, to help promote a level playingfield. The reforms we are proposing are similar to the proposals included in the bipartisan bill that Mrs. Johnson, Mr. Stark, Mr. Cardin, Mr. Kleczka, Mr. Ensign, and others have worked on in the last session and have continued to work toward this year. Among the provisions would be elimination of exclusions for pre-existing conditions, standardization of benefit packages, and one proposal in our plan that is not yet in other legislative proposals that would require community rating for Medigap plans as we now require it for Medicare HMOs.

There are obviously a lot of other pieces in this package as well. Let me just make one last point in my statement before I conclude.

I said that we weren't going to talk about our payment policy proposals, and I would try to keep that to myself until people have questions about them. But I do want to emphasize that our actuaries believe that the sum total of all our proposals relative to managed care in the Medicare Program will take the already rapid growth rate in enrollments in such programs and accelerate it even further during the budget period.

What this shows is that, under the baseline, one would expect about 19 percent of Medicare beneficiaries to be enrolled in managed care by the year 2002. According to our actuaries, they estimate that 22.5 percent of beneficiaries will be enrolled in such plans, were all our proposals to be adopted.

The CBO, in their scoring of the President's budget, has projected less growth, but that is in part because their baseline is already higher and, in fact, projected Medicare enrollments under

the President's plan, under both OMB and CBO scoring, are in the range of 22 percent in the year 2002.

Obviously, we still have much work to do in the area of quality improvement of managed care, as in all parts of the Medicare Program, but as the managed care market further expands and evolves, we hope to begin reaping the benefits of innovative payment, administrative and patient care strategies. We need to expand the choices available to our beneficiaries, enhance consumer protections, and provide much better comparative information to assist beneficiaries in making choices, and to assist us in our responsibilities to monitor the performance of our contractors. Obviously, payment reform is connected to all of these.

We very much look forward to working with you, Mr. Chairman, and with the other Members of the Subcommittee and Members of Congress, to reach our shared goals of strengthening the Medicare Program, extending the expected life of the Hospital Insurance Trust Fund, increasing the number of choices available to Medicare beneficiaries, and assuring all of our citizens that not only are we responsible for the quality of care they will receive in managed care plans, but that we will have the tools and the capabilities with which to carry out that commitment. We look forward to working with you to accomplish all of these goals.

I thank you again for the opportunity to be here today, Mr. Chairman.

[The prepared statement follows:]

Statement of Hon. Bruce C. Vladeck, Ph.D., Administrator, Health Care Financing Administration

INTRODUCTION

Mr. Chairman, I am very pleased to be here today. I would like to describe how the Health Care Financing Administration (HCFA) is working to ensure that the availability of managed care options will enhance health care for Medicare beneficiaries. It is important that we clearly define and support measures to promote quality of care, not only for beneficiaries enrolled in Medicare managed care plans, but for all Americans in all types of health plans.

Managed care options have been a part of Medicare since the program's inception. With the signing of the first risk contracts authorized under the Tax Equity and Fiscal Responsibility Act in 1985, managed care plans proliferated and today have become an essential part of the Medicare program. As of January 1, more than 4.9 million beneficiaries have enrolled in 350 Medicare managed care plans, two thirds of which are risk contractors. Risk plan enrollment for the first six months of 1996 increased by more than 520,000 beneficiaries—an annual growth rate of more than 30%. This increase is consistent with the rapid rate of program growth in recent years. In 1994, enrollment grew by 25 percent, in 1995, the growth was 36 percent.

In a managed care plan, a network of doctors, hospitals, skilled nursing facilities and other providers offers comprehensive, coordinated medical services to plan members on a prepaid basis. Except in emergencies, services must be obtained from health care providers that are part of the plan. Care may be provided at a central facility or in the private practice offices of the doctors and other professionals affiliated with the plan.

We have found that the managed care option is attractive to many beneficiaries. In many cases, enrollees can receive the same financial protection afforded by Medicare supplemental—or "Medigap"—policies without paying a premium. In addition, most plans provide benefits not covered under the Medicare program, such as routine vision care, dental care, and prescription drugs, at little or no additional cost to the beneficiary. I should point out, however, that the ability of managed care plans to provide additional benefits is due in part to the inadequacy of Medicare's payment methodology, which we have proposed to address in this year's budget. Beyond value measured in dollars and cents, managed care plans have the potential

to provide value that can be achieved when services are coordinated and when the focus of care is on prevention and "wellness."

Our mission in HCFA is to serve our Medicare and Medicaid beneficiaries. Under this Administration, HCFA's efforts are firmly focused on obtaining the best value for our beneficiaries. We work in partnership with managed care plans in this task, but as I will describe later in my testimony, we have not hesitated to take enforcement actions when warranted.

BENEFICIARY PROTECTIONS

Current law provides beneficiaries enrolling in managed care plans a wide variety of protections, many of which are not received by most commercial enrollees. Let me take this opportunity to outline briefly the protections that beneficiaries enjoy under current law and areas where improvements are warranted.

- Beneficiaries must receive clear and accurate information about the implications of their choice of a managed care option—Current law requires that plans provide certain information to all prospective enrollees including explanations of benefits, premiums and cost-sharing, lock-in requirement, and grievance mechanisms. However, we believe that more needs to be done to educate consumers about their health care alternatives and later in my testimony I will describe our plans for improvement in this area.

- Beneficiaries cannot be subjected to health screening or preexisting condition limitations—Current law is clear in this area. We enforce this requirement through careful monitoring of all marketing materials and activities of contracting plans, and by reviewing beneficiary grievances and appeals.

- Beneficiaries must have access to medically necessary and appropriate care—Before receiving a contract, all plans must meet Federal standards which guarantee beneficiary access to medically necessary services. HCFA is committed to ensuring that HMOs adhere to these Federal standards.

- Beneficiaries must have access to procedures to resolve grievances and access to a neutral third party for appeals—While this is one area where Medicare's protections are significantly beyond those generally available to managed care enrollees in the private sector, we believe that improvements are necessary. Our plans for achieving these improvements will be explained in a subsequent section.

- Beneficiaries' care is reviewed both internally and externally—Plans must have internal quality review mechanisms in order to receive a contract. PROs are responsible for external quality review. We have been working closely with other payers and the industry to make significant improvements in this area and, later in my testimony, I will outline these initiatives.

- Beneficiaries are protected from the risk of discontinuous or inappropriate care that could result from the financial instability of a plan—Under current law, plans must be fiscally sound and must have a plan for protecting beneficiaries in the event of insolvency.

- Beneficiaries' out-of-pocket expenses are limited—Under current law, Medicare managed care plan enrollees are protected by limits on premiums and cost-sharing and by prohibitions against balance billing.

We have also been working toward enhancing beneficiary protections. Some steps can be taken under current law, while other actions would require legislation.

- Improving the Appeals and Grievance Processes: The appeals and grievance process serves as a check and balance on contracting plans and helps to ensure that beneficiaries obtain all appropriate and medically necessary services. Improvement activities include an expedited appeals process for certain time-sensitive situations, shortened time frames for all other reviews involving service denials and terminations, and improved health plan accountability on the results of appeals and grievances. However, we cannot afford to be complacent in the face of recently publicized concerns, and streamlining the appeals process is one of our highest priorities.

- Unrestricted Medical Communication: The Medicare statute requires that contracting health plans must make all covered services available and accessible to each beneficiary as determined by the individual's medical condition. In fee-for-service, Medicare beneficiaries are made aware of the full range of treatment options by their physicians. Managed care enrollees are entitled to the same advise and consultation. This is a basic right of the patient and we have communicated the prohibition against "gag" provisions in a policy instruction to all health plans.

- Post-Breast Cancer Surgery Hospitalization: The national attention given to coverage of mastectomies indicates that there is a need for greater oversight. We are committed to preventing sub-standard care in this area since Medicare pays for one-third of all mastectomies. By law, Medicare beneficiaries who receive

mastectomies are entitled to coverage for all medically necessary care. The decisions about what is medically necessary should be made by a woman and her doctor. To emphasize this, on February 12, 1997, we sent a policy letter to all managed care plans, making it clear that they may not set ceilings for inpatient hospital treatment or requirements for outpatient treatment. Similarly, we will soon be reinforcing this message in Medicare's fee-for-service sector.

- Physician Incentive Plans: Effective January 1, 1997, the Physician Incentive Plan Final Rule required managed care plans with Medicare or Medicaid contracts to disclose information about their physician incentive plans to HCFA or the State Medicaid agencies, before a new or renewed contract receives final approval. Plans whose compensation arrangements place physicians or physician groups at substantial financial risk must provide adequate stop-loss protection and conduct beneficiary surveys.

- Prudent Layperson: The Administration's plan clarifies the obligation of Medicare managed care plans to pay for emergency services rendered to their enrollees. By using HCFA's definition of "emergency services" as those services that a "prudent layperson" would reasonably believe to be needed immediately to prevent serious harm to the patient, States will be better able to determine similar requirements for commercial managed care enrollees.

- National Marketing Guidelines: To ensure uniform interpretation and provide beneficiaries with accurate and clear information about managed care plans, we have developed the Medicare Managed Care National Marketing Guidelines. These Guidelines, which will be released next month, were developed in cooperation with the American Association of Health Plans and representatives of the health care industry.

- Beneficiary Information Publications: HCFA and its Department of Health and Human Services (DHHS) partner agencies have developed several publications to inform Medicare beneficiaries of their rights and options. These beneficiary advisory publications answer frequently-asked questions about HMO enrollment and disenrollment, potential fraud and abuse, and the appeals process. Also, the latest edition of the Medicare Handbook was sent to all 37 million Medicare beneficiaries and it is our goal that all beneficiaries receive an updated handbook every year.

- Comparative Information: We want to provide all Medicare beneficiaries comparative information that would assist them in making choices. In the President's FY 98 Budget Plan, we propose that comprehensive comparative information on all plan options, including Medigap, be provided to Medicare beneficiaries and be funded by the plans. In the interim, we are working on making comparative information available on the Internet and to beneficiary insurance counseling centers. Phase I of this project will be available by June 1997, and will provide comparative market data about HMO benefits, premiums, and cost-sharing requirements. Currently, many of HCFA's regional offices sponsor and disseminate comparative information for local beneficiaries. HCFA is currently working to implement a Competitive Pricing Demonstration in Denver to test a range of new education and information resources for beneficiaries—including new formats of printed materials, in-person seminars, and a 1-800 call center, all coordinated by a HCFA-sponsored third party. The goal of these resources is to help beneficiaries understand their options under Medicare and help them make the best choices—whether it is fee-for-service, Medigap, or managed care.

- Community-based Medicare Information Resource: This past October marked the opening of a pilot project to provide beneficiaries with the latest Medicare information in a convenient, one-stop, personal service facility. The test site for "Your Medicare Center" is a Philadelphia shopping mall and is staffed by HCFA employees who explain managed care options, resolve concerns, and correct records. This innovative project will allow the public's concerns about entitlement, managed care choices and enrollment, Medigap insurance, coverage, premiums, and appeals to be answered promptly and efficiently. Additional services including educational seminars on managed care-related issues and health screening will also be available, using technology such as interactive video-conferencing and computerized information kiosks.

IMPROVED MONITORING AND ENFORCEMENT

All of the beneficiary protections that I have just outlined are only words on paper unless there is an explicit commitment to enforcement. I am proud to say that this Administration has fostered significant improvements in oversight and monitoring of managed care plans. We have initiated a program of special investigations that may target a specific compliance problem, or review all plans in a heavily saturated market area. Protocol-monitoring processes have been revised to improve clarity and

establish more consistency in the methods used to evaluate contractor operations. National guidelines for marketing materials have been developed to improve our monitoring of plan compliance with statutory and regulatory requirements.

For the first time in the history of the program, we have begun to impose intermediate sanctions in response to certain plan activities. If we find the same compliance problem in successive monitoring reviews, we are no longer treating the recurrence as an isolated event, but instead are taking enforcement actions. Under these sanctions, we can require a contracting organization to suspend marketing activities or enrollment of new members; in some circumstances we will suspend payments to the plan for new enrollees.

Finally, in regard to monitoring and enforcement, we also have several activities in the planning stages. First, we are evaluating our process for reviewing and approving applications for managed care contracts in order to identify potential problems with a plan's ability to meet contracting requirements before we approve the contracts. Second, we are redesigning our data system to facilitate cross-plan comparison of enrollments, disenrollments, appeals processing, complaints, quality and fiscal soundness in order to identify aberrant patterns that warrant investigation. Lastly, we have begun discussions with State insurance commissioners regarding actions that could be taken to coordinate activities. These include eliminating some duplicative oversight functions, and maximizing the sharing of information, especially with regard to plans experiencing financial difficulties. The importance of consistent and conscientious quality monitoring cannot be overemphasized, and I would like to devote the rest of my testimony to describing the progress that we have made in developing quality measurements and in fostering quality improvement.

QUALITY INITIATIVES

The argument for the potential of managed care to improve quality is well known. It starts with a critique of fee-for-service. Fee-for-service care tends to be fragmented with a focus on acute rather than preventive services. Economic incentives are in the direction of over-utilization of health care services. As a result, under fee-for-service, there tends to be an inappropriate and costly allocation of existing health care resources. It is then argued that the capitated prepayment made to managed care allows plans to organize care and re-allocate resources to address, in a coordinated and systematic way, the needs of each patient. In managed care, unlike fee-for-service, the organization is accountable for improving the well-being of the patient. This provides an opportunity, more elusive in fee-for-service, to improve the quality of care being furnished.

The flip side to the argument is also well known. In managed care, there is the potential for "under-service" and poor quality, if plans try to maximize short-term profits by not delivering appropriate care. The goals of our quality initiatives are to develop mechanisms to measure quality and to hold plans accountable for quality improvement. We have two approaches toward achieving these goals. The first approach is to use utilization data or encounter data to address "inputs" into the delivery of care. Most current performance measures are "process measures." Process measures refer to clinical interventions (tests, medications, procedures, surgery) which are believed to lead to favorable patient outcomes. While this approach has limitations, encounter data and process measures provide significant insight into the quality of care.

The second, and potentially the most efficient strategy for clinical performance measures, is to move toward outcome measures. The problem is that the science of outcomes measures is in its infancy. The movement towards better outcomes measures is critical for HCFA, like-minded purchasers, and beneficiaries in order to hold plans and providers accountable for the care they deliver. HCFA and the Agency for Health Care Policy Research (AHCPR) have been active in promoting research to identify these measures. With such measurements in hand, HCFA and the public will be able to objectively compare managed care to itself and to fee-for-service, and to determine whether managed care is living up to its potential to improve the quality of care. However, more research is needed, especially with regard to the health care needs of the poor, elderly, and other vulnerable populations, and with how to present this information effectively to beneficiaries.

As I indicated earlier in my testimony, a major focus of our efforts in recent years has been in working with our partners in the managed care industry and with other payers to accelerate and standardize the development of outcomes measures.

- HEDIS 3.0: The latest iteration of the Health Plan Employer Data and Information Set, HEDIS 3.0, reflects a joint effort of public and private purchasers, consumers, labor unions, health plans, and measurement experts, to develop a comprehensive set of measures for Medicare, Medicaid, and commercial populations enrolled

in managed care plans. As of January 1, 1997, HCFA is requiring Medicare managed care plans to use HEDIS. This will facilitate comparison of plan performance measures and permit HCFA to hold plans accountable for the quality of the care they provide. HEDIS measures eight components including: effectiveness of care; access/availability of care; satisfaction with the experience of care; health plan stability; use of services; cost of care; informed health care choices; and health plan descriptive information.

HCFA, working with the HEDIS Committee on Performance Management, was instrumental in adding functional status for enrollees over age 65 as a measure in the "effectiveness of care" category in HEDIS 3.0. This will be the first outcome measure in HEDIS that will longitudinally track and measure functional status. It addresses both physical and mental status through a self-administered instrument which determines whether the beneficiary perceives that his or her health status has improved, stayed the same, or deteriorated. In addition, six other measures that impact on Medicare beneficiaries have been added to the "effectiveness of care" category, including: mammography rates, rate of influenza vaccination, use of retinal examinations for diabetics, outpatient follow-up after acute psychiatric hospitalization, and utilization of beta blocker in heart attack patients.

- Foundation for Accountability: The Foundation for Accountability (FAcct) is a new non-profit organization dedicated to helping purchasers and consumers obtain the information they need to make better decisions about their health care. As Federal Liaisons to the FAcct Board of Trustees, HCFA is joined by other public and private sector partners, including the American Association for Retired Persons, the Department of Defense, the Office of Personnel Management, Ameritech, and American Express. The underlying premise of FAcct is that better health care information, assembled from the consumers' point of view, should help steer Americans toward the highest quality care. Specifically, FAcct endorses and promotes a common set of patient-oriented measures of health care quality. Together, HCFA and AHCPR have played major roles in the development of FAcct quality measures for depression, breast cancer and diabetes. HCFA and the ASPE also recently contracted with the RAND Corporation, a non-profit research organization, to refine and test three sets of outcome measures for implementation in 1998.

- Medicare Beneficiary Survey: In cooperation with HCFA, AHCPR initiated the Consumer Assessment of Health Plans Study (CAHPS) to design a Medicare beneficiary survey. This survey quantifies Medicare enrollee responses about satisfaction with plan providers, access to services and providers, availability of services, and quality of care. Beginning January 1 of this year, HCFA is requiring all health plans to use CAHPS, which is now available to the public. HCFA plans to administer the survey through an objective single third party vendor in order to ensure comparability.

In addition to our quality measurement initiatives, we are actively involved in promoting quality improvement.

- Projects to Assess Ambulatory Care in Managed Care Settings: The Medicare Managed Care Quality Improvement Project (MMCQIP) is designed to enhance HCFA's ability to assess how well the ambulatory care process in managed care is meeting the needs of beneficiaries. At this time, we are evaluating the care received by Medicare managed care plan enrollees diagnosed with diabetes mellitus, and the incidence of screening mammography in a sample of enrolled beneficiaries. The PROs in five states (California, Florida, New York, Pennsylvania and Minnesota) and 23 Medicare-contracting HMOs are collaborating on MMCQIP. In addition, an on-going sister project, utilizing the PROs in Maryland, Iowa and Alabama, will analyze the same measures in the fee-for-service setting. The initial finding is that there is room for improvement in both managed care and fee-for-service in these two areas.

- Medicare Choices Demonstration—An important component of this demonstration is improvement in our comprehensive quality monitoring system. Under the Choices project, we will be developing and testing quality/outcomes and risk adjustment measurements systems that use encounter data (health care services received by enrollees); all participating plans will be required to provide 100% encounter data. We have contracted with the RAND Corporation to assist us in designing such a system, which will be refined further using the "Choices" data.

Other important Medicare managed care quality initiatives include the establishment of new requirements for Medicare managed care plans in the areas of quality improvement activity; health information systems; health services management; and member rights and responsibilities. In addition, as part of a project to improve efficiency in monitoring and oversight, teams of HCFA and PRO staff are being formed to target a review of managed care plans' internal quality assessment and improvement programs; we have similar quality improvement initiatives for Medicare fee-

for-service plans. Our budget also includes a provision to give us the authority to develop an integrated quality management system, so that we can assess more comprehensively the quality of care provided under fee-for-service.

THE PRESIDENT'S 1998 PROPOSALS

Everyone agrees that "knowledge is power," but at no time has the dissemination of information been so critical to health care choice. Beneficiaries are often stymied in their health plan choices by an overload of esoteric and confusing information, making it difficult to determine which plan best meets their needs. We seek to empower beneficiaries by ensuring wider and more consistent dissemination of health plan information in a format that is easier to understand.

The President's 1998 Budget Plan includes several proposals affecting areas I have already discussed. We believe these changes are important to achieve our stated goals of preserving the solvency of Medicare and enhancing beneficiary protections and choices. Specific actions we have taken to expand and enhance beneficiaries' choices include:

Expanding Beneficiary Choices

- Expanded PPO/PSO Options—Currently, HCFA can contract with Federally qualified Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) to serve as Medicare managed care plans. The Administration believes that Medicare beneficiaries should have more managed care choices, comparable to those available in the private sector. Thus, the President's budget would expand managed care options to include Preferred Provider Organizations (PPOs) and Provider Sponsored Organizations (PSOs). We believe that direct contracts with alternative managed care models such as PSOs are the key to expanding managed care to rural areas.

The President's budget proposes that beneficiaries receive comparative materials on all of their coverage options—both managed care and Medigap. To help beneficiaries compare various plans, standardized packages for additional benefits offered by managed care plans and the Medigap plans would be developed. Medigap plans would be required to operate under the same rules followed by Medicare managed care plans. These Medigap reforms would require annual open enrollment, prohibit imposition of pre-existing condition exclusion periods, and prohibit differential premiums based on age or health status.

- Annual Open Enrollment—Under Federal law, aged individuals have a once in a life-time opportunity to select the Medigap plan of their choice when they first join Medicare at age 65; individuals who become eligible for Medicare because of a disability or end-stage renal disease beneficiaries have no such choice. If a beneficiary enrolls in a managed care plan and is later dissatisfied, he or she may not have the opportunity to select the Medigap plan of his or her choice; for example, drug coverage may be unavailable due to the individual's poor health status. As a result, some beneficiaries are reluctant to try managed care or are fearful of being locked into managed care options with no opportunity to return to fee-for-service and Medigap. The President's budget gives all new beneficiaries, not just aged beneficiaries, the opportunity to choose the managed care or Medigap plan of their choice when they first enroll in Medicare. In addition, each year all Medigap and managed care plans will have to be open for a one month coordinated open enrollment period. Additional open enrollment opportunities will be available under certain circumstances—such as, when a beneficiary's primary care physician leaves a plan or when a beneficiary moves into a new area.

- Elimination of Pre-existing Condition Exclusions—In addition to addressing open enrollment, there are other Medigap reforms included in the President's budget. We would like to eliminate the ability of Medigap insurers to impose pre-existing condition exclusion periods. Under the policy in the President's budget, a Medigap plan cannot impose an exclusion period for a beneficiary who has recently enrolled in another Medigap plan, Medicare managed care, or employer-based plan. This is similar to the policy included in a bi-partisan bill introduced by Mrs. Johnson and others during the last session and we look forward to working together toward enactment this year.

- Community Rating for Medigap Plans—Our final Medigap reform addresses rating. There are currently no federal requirements regarding the rating methodology used by Medigap plans. As a result, plans can use low premiums to entice beneficiaries to enroll in their fledgling stages, but as the company matures it raises the premiums to unaffordable levels. Under the President's budget, Medigap plans would be required to use community rating to establish premiums. The movement to community rating would be subject to a timetable and transition rules developed

by the NAIC. Given that managed care plans are required to charge all enrollees the same premium, Medigap plans should not be allowed to charge differential premiums based on age. Also, if choice is an important goal, then premium structures such as attained age rating, which in effect make Medigap unaffordable as beneficiaries age, should not be allowed.

Quality Initiatives

- Quality Measurement System: The President's plan would authorize the Secretary to develop a system for quality measurement which would replace the current requirement that managed care plans maintain a "level of commercial enrollment at least equal to public program enrollment," which is often referred to as the "50/50 rule." In the interim, the Secretary could waive the 50/50 rule for plans in rural areas and for plans with good "track records" or in other instances the Secretary deems appropriate.

PRUDENT PURCHASING FOR MANAGED CARE PLANS

Through a series of policy changes, the Administration's plan would address the flaws in Medicare's current payment methodology for managed care. Specifically, the reforms would create a national floor to better assure that managed care products can be offered in low payment areas, which are predominantly rural communities. In addition, the proposal includes a blended payment methodology, which combined with the national minimum floor of \$350 per member per month, would dramatically reduce geographical variations in current payment rates. The plan would reduce reimbursement to managed care plans by approximately \$34 billion over 5 years. An assessment of the impact of the President's Medicare managed care proposals should consider the plan as a whole—both the merits of the components that have a budget impact as well as other non-budget components, some of which were discussed above. It should also be kept in mind that Medicare per capita costs, upon which managed care payments are based, have grown over the past two years by approximately 16 percent, while growth in payments to plans on the commercial side have been virtually flat. Our actuaries project that the combined effect of the managed care reforms, both the proposals with a budget impact and those without budget impact described earlier, would result in increases in managed care enrollment compared with present law. By fiscal year 2002, under the President's plan, 22.5 % of Medicare beneficiaries would be enrolled in managed care plans, compared to 19.3% under current law.

CONCLUSION

We are aware that there is still much work to do in the area of quality improvement of managed care. As the managed care market further expands and evolves, we expect to reap the benefits of innovative payment, administrative and patient care strategies. Some of these have already been applied to our Medicare modernization efforts and will contribute to Medicare savings. We would like to expand the choices available to beneficiaries; enhance consumer protections; provide comparative information to assist beneficiaries in making health care choices; and reform the payment methodology to plans. These goals are shared by all with a commitment to consumer protection and there is certainly a consensus that quality and availability of health care is our number one priority. In cooperation with Congress, the health care industry, and the research community, we will reach our goals—to extend the solvency of Medicare, and guarantee its existence for future generations of Americans. I look forward to working with you to accomplish these goals.

Chairman THOMAS [presiding]. Thank you very much, Mr. Vladeck. I apologize for not being here at the beginning of the hearing. We were finishing the House oversight on the budgets of the other Committees.

In talking about budgets, this is the first chance I have had to see you since we got the CBO numbers, and I'm just partially curious and would like to know your reaction, the administration's reaction.

If you thought \$100 billion over 5 years as a savings for Medicare was an important number, not just in terms of what it did in dollar amount but the number 100—because with the CBO scoring of the OMB projection, it actually turned out to be \$82 billion rather than \$100 billion—I guess my question is, Does the administration now think 82 is good enough, or are they going to go back and produce a CBO-scored \$100 billion? How important was the \$100 billion?

Mr. VLADECK. Well, Mr. Thomas, a lot of these questions go beyond the issues of Medicare proposals, *per se*, into the broader process of reaching agreement on a complete balanced budget package and a complete balanced budget path—

Chairman THOMAS. You don't mean to say by that, that the President's tax cuts are dependent upon the Medicare number?

Mr. VLADECK. No. I would say that I think there needs to be some greater agreement between the Congress and the President on the kind of scorekeeping that's going to be done as a first instance, and some of the broader parameters of the negotiations, before one can talk at all about the appropriate Medicare number.

Chairman THOMAS. By that do you mean that you want us to disavow CBO's scoring and go to some agreed-upon scoring rather than CBO's scoring?

Mr. VLADECK. What I should have said, or meant to say, is that I think these questions are subsumed in larger discussions as to how the budget process is going to be conducted and what some of the parameters of that will be, on which I'm not able to comment.

I would only say that we were disappointed, but not surprised, by the CBO scoring of the package. We think it's a good package. But whether we have to look at additional proposals or talk further with CBO about the appropriate scoring, there are a set of discussions that will have to take place in this broader context, about which I can't tell you very much.

Chairman THOMAS. This whole business of additional benefits in the risk contracts above what would otherwise be required, ProPAC has recommended to us that, at least in an initial phase, we really ought to look at trying to standardize what it is we're talking about, in terms of the definition of a particular product, or the term used in referring to it, so that when you see something mentioned in one place and see it mentioned in another, it at least means the same thing—which I think is a big step forward.

Correct me if I'm wrong, but I believe the President's proposal, notwithstanding the failure to meet the number he said he met, talked about standardizing packages—that is, the benefits themselves—so that you could look at one package versus another or, more importantly, that only certain packages would be appropriate, more of a "one size fits all" benefits addition.

What is it that the President's program actually entails about the question of standardization?

Mr. VLADECK. If I understand correctly, we had used the model of Medigap legislation as a notion here, not that we would prescribe the supplemental benefits that would be offered by managed care plans, but that based on what's in the market now, we would describe a group of standard packages of supplemental benefits. Depending on what plans are actually doing, these packages would have somewhat greater standardization of the benefits themselves

than is currently in the market, which would really facilitate the process of comparison. So you could now say a Medigap type B policy offered by one carrier is the same as a Medigap type B policy offered by another carrier. This would facilitate the comparison of supplemental benefit packages offered by HMOs in the same area.

It was not our intent to prescribe other new benefits, nor to mandate one particular set of supplemental benefits for any set of plans. It was just an effort to facilitate comparison by defining standard packages of benefits and having them, as much as possible, conform to the standard supplemental benefits in Medigap.

Chairman THOMAS. But you talk about packages. Isn't it also possible, or were you contemplating standardizing specific components rather than packages? So that if you talk about a prescription drug benefit, there would be a standardized prescription drug benefit as opposed to prescription drugs envisioned as a package.

Would the standardization as envisioned in the President's plan go to the particular benefit as well?

Mr. VLADECK. It would have to, to some degree. Again, this would not exclude alternatives, but only say if package A includes a prescription drug benefit, with a \$1,000 annual limit, and a \$10 copay, then someone who is offering a different drug benefit couldn't describe it as package A.

Chairman THOMAS. And if you standardize particular benefits, don't you then, almost inevitably, lead to a hierarchical arrangement, or a communication with individuals, as to which is a preferred benefit over another, even on a statistical basis of the number of people who choose it?

Mr. VLADECK. If you look at the experience with Medigap, where presumably the order of A through H implies some implicit hierarchy, I don't think the choice of either what plans have been marketed by the Medigap carriers, or where the beneficiaries align in terms of selection of their plans, fits with the notion that some hierarchy has been imposed on that.

Chairman THOMAS. I asked at the last hearing—it seems we have two of these a week now, so I'm trying to keep track of them—that if you had a first dollar availability to provide an additional benefit—this is pretty obvious, but at least we've got it on the record—that virtually all of the health plans testifying before us, if they had a first dollar available, would make it available in a buy-down arrangement in terms of no cash out of the pocket of the beneficiary. The second dollar, in essence, would be spent for, as you might guess, prescriptions. And then the third would be for—someone might think I'm unfairly characterizing it as a second tier of benefits—but it is that next group without a clear preference between vision, dental, and the other structures.

Now, that might appear to be obvious, which I think it is, if you look at what people think is important.

How would you envision a standardization approach from HCFA in dealing with those three semidistinct areas of dollar buydown, or would you talk about a benefit package in comparison to another, with an actual cash dollar buydown versus a product, like paid prescription or service, vision, dental, and so on?

Mr. VLADECK. Again, it's my impression, Mr. Chairman, that, in fact, in most parts of the country, the range of supplemental pack-

ages that are offered is not that broad, that, in fact, there is an implicit "hierarchy" or "ordering" in the marketplace that is pretty much what you described. So clearly, the first thing one would need to do to try to characterize those packages in a standard way would be to just pull together the information we have about what's out there.

Variations in benefit packages would range from those minimizing the out-of-pocket expenses, and then probably others which offer that plus a drug benefit, perhaps capped at \$1,000. I think there are several variations on the drug benefits out there.

Chairman THOMAS. Actually, if we implemented other parts of the President's plan, this would be a purely theoretical discussion, because if you go from 95 to 90 percent, there aren't going to be any additional benefits to talk about anyway. So it may be—

Mr. VLADECK. I think you're underrating the plans, Mr. Chairman.

Chairman THOMAS. Well, we'll see.

I have in front of me the February 12 Office of Managed Care operational policy letter having to do with HMO outpatient mastectomies. As you recall, we did some work trying to find out how many folk were covered by this edict, and we used the 1995 New York numbers.

You will recall, in terms of the number of mastectomies, there were slightly more than 7,000; 98 percent of them, 6,900-plus, were actually inpatient. Of the 124 outpatient, 122 were fee-for-service, which leaves 2 which were HMOs.

If we extrapolated that across the country, I thought at the time it was a rather remarkable letter to send out to that percentage of folk in the overall area of concern about mastectomies. As a matter of fact, the language actually said that the outpatient setting or limited hospital stay may be appropriate. However, "these practices may only be used when they have been determined to be appropriate by the patient and her physician," after assessment of the patient's individual circumstances, apparently putting the Department of Health and Human Services in contravention to the President regarding legislation that he wishes to support, which would remove the judgment of the physician interacting with the patient, in essence, and replace it with a fixed stay.

When you last appeared before the Subcommittee, I asked you about the fee-for-service and you said it was more difficult, it's not quite the same—

Mr. VLADECK. Right.

Chairman THOMAS. I said why didn't you hold back in terms of releasing, and my understanding is that yesterday you released it to the fee-for-service.

Mr. VLADECK. Yes. Actually, there are two separate communications, one to our carriers and their intermediaries, and a second to our peer review organizations, which are similar in content. Both, in fact, have largely the same language as the operational policy letter sent to HMOs.

Again, given the different responsibilities of those different contractors, I'm going to ask them to make sure this information is conveyed and adhered to as they carry out their separate responsibilities.

Chairman THOMAS. Was the first letter sent in response to complaints that had come in?

Mr. VLADECK. I don't know that we ourselves have received beneficiary complaints. Obviously, I've been aware of the discussion among Members of Congress and in the media about the expression of concerns about—

Chairman THOMAS. Was the second letter sent in response to complaints?

Mr. VLADECK. The second letter was sent because you quite correctly pointed out to us that the concerns we conveyed in those letters should be just as appropriately conveyed on the fee-for-service side as on the managed care side. We took that advice and criticism to heart.

Chairman THOMAS. So, in essence, the second two letters just sent come under the category of CYA, as we say?

Mr. VLADECK. No, the second—they come under the category of "occasionally we get very good advice and guidance and we try to follow it."

Chairman THOMAS. Had you sought it in terms of the issuing of the first one, you wouldn't have had to necessarily do what you did with the second one, compounding a concern where perhaps there is none isn't necessarily a step forward. I do commend you for indicating that a physician and a patient ought to be the ones who make the decision, and if you could buck this over to the White House, we would be appreciative of the White House understanding the position of HHS on the issue.

Thank you.

Does the gentleman from California wish to inquire?

Mr. STARK. Thank you, Mr. Chairman.

Bruce, you guys are planning to drop the 50-50 rule?

Mr. VLADECK. It's called for in the budget proposal, yes, sir.

Mr. STARK. Is that a good idea until you have something to replace it?

Mr. VLADECK. No. I think the legislation contemplates the issuance of a set of regulations at the time of the elimination of the 50-50 rule.

Mr. STARK. And have some standards?

Mr. VLADECK. The regulations would contain the set of standards, on which we are now working.

Mr. STARK. Would you agree that it would be a good idea not to discontinue the 50-50 rule until you've gone through the whole process, the hearings, the comments, and until the regulations are in place?

Mr. VLADECK. Well, frankly, from an operational point of view, I think once our proposed standards are published, even though they don't yet have the force of rule, we are actually riding along on a process that is already going on even before we engage in rule-making.

Mr. STARK. What would be wrong with waiting, to keep the 50-50 until you're ready to substitute something for it?

Mr. VLADECK. Well, the particular issue is the concern we have heard from many rural communities in the United States, with their relatively high proportion of Medicare beneficiaries, that the 50-50 rule is a major impediment.

Mr. STARK. I understand that. But you also recognize the importance of having something to replace it.

Mr. VLADECK. That's correct.

Mr. STARK. So what I'm saying is, the only reason that wouldn't happen promptly is because you don't get the regulations out on time. So if we were to say you can't remove it until the regulations are in place, you would hurry up and get the regulations in place, right?

Mr. VLADECK. It's a balancing act and, obviously, in different folks—

Mr. STARK. Don't balance it on the backs of the beneficiaries; how's that?

Mr. VLADECK. I set that one right up. [Laughter.]

Mr. STARK. AARP has raised some questions, and GAO did, and perhaps you can tell me. You talk about knowledge being power. Again, the least powerful people seem to be the beneficiaries. But let me say this a different way.

People are talking about the descriptions of policies, benefits and costs, disenrollment and complaint rates, summaries of your site visits. Is there any information you are now collecting that is not available to the public?

Mr. VLADECK. I believe that some of the material we collect for financial reviews of plans is not generally available to the public.

Mr. STARK. Is there any reason, if that were to help us look at distortions or different loss ratios, that that information shouldn't be available in a sanitized form?

Mr. VLADECK. Well, let me say two things. One is—

Mr. STARK. Or in a summary form.

Mr. VLADECK. As a general principle, I believe information collected by government agencies ought to be available to the public. Our experience on the analogous issue with hospitals and nursing homes over the last 20 years is that the raw material and the version that is collected and maintained by us or our agents tends to be of limited utility and that we may better serve—

Mr. STARK. But I think there are a lot of people, like the AARP and Concerned Citizens, a whole bunch of groups, who would be glad to take that raw data and put it into an understandable format, if you don't have the time or the resources. But not having it available would make it difficult.

So you would agree with me that it all ought to be available, conveniently, and in a timely fashion?

Mr. VLADECK. Again, with the exceptions of certain privacy interests, yes, sir.

Mr. STARK. The other issue is a rather subjective area, but you also suggest in your testimony that these protections for beneficiaries are only words on paper unless there is an explicit commitment to enforce it.

For example, in the history of Medicare managed care plans, how many plans have been terminated for the program by action of the Federal Government, not because they went broke?

Mr. VLADECK. I think it's a small, single-digit number, but I'm not sure offhand.

Mr. STARK. And that's because they stole \$30 million and Mr. Acari went to wherever the hell he's hiding out now.

How about sanctions or fines per year? Is it 25, 50, 100, single digit?

Mr. VLADECK. I don't have information available, but in the use of sanctions, I think it was pretty much nonexistent prior to 1994, and since then we're talking about the sanction of suspending enrollment or limiting enrollment a handful each year.

Mr. STARK. I don't think it does any good to put a \$10,000 fine—that somebody doing business of \$1 billion a year is going to pay a \$10,000 fine. That's probably costing them less than answering your letter, which probably doesn't do much good, either. They look at the letter, write you an answer, throw it away, and that's the sum total of any wrist slapping that we do.

I don't think it should be a cliff, but unless there is a serious result for the plan that isn't living up to standards—after we've all agreed that that's what they should do and there's a rule out there—we're not going to see much happen, particularly if the only sanction you have is to close them down, which we know almost never happens, and perhaps that's OK.

But I would hope you would come to us, along with the Justice Department and the Inspector General, with some sanctions that would build in some financial severity for the plans who decide they really don't want to make a good faith effort to correct their problems.

A little bit of jail time for the chief executive officer, probably in relation to the millions of dollars they make in salary—you know, a month per million. Don't let them pass the buck down. That's a trick we all learned in Congress. We all blame our staff. No, no. Let's make the chief executive officer serve the time, and then I think you might find that all these problems will disappear very quickly.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you, Mr. Stark.

Before I call on the gentleman from Nevada, let me just follow on with that.

You're beginning to collect HEDIS 3 information. Are you anticipating creating a floor in terms of a standard? Because one of the opportunities I see here is, as you collect information, you can clearly see those that are not being used by Mr. Stark as an example, and those that are being used by Mr. Stark, and you can create a preferred plan or you can create an incentive structure that has these folk winnowed out in a way that isn't so much hanging people—unless they deserve to be hanged—but, in fact, creates model programs that graduate people into preferred structures. If we're going to drive that number up, we need more plans that are the preferred model plans, rather than simply shutting plans down because they had no guidance and didn't understand clearly what it was that was expected of them to get their funding.

Mr. VLADECK. Let me tell you that we are now in the midst of an extensive internal debate around the following question: Once we have information that more quickly and accurately permits us to depict the quality of performance of a plan, to what extent do we try to create an explicit incentive for plans to meet certain levels on the high end rather than just exceed the low end threshold?; to what extent do we believe that just getting that information out

will cause the market to respond to reward the better performers?; and to what extent should we let the market reward the better performers and use that information to raise the floor over a period of time?

How we can do all those things in the context of a public program, with requirements for consideration for the rights of the providers, so on and so forth, are a set of issues that we're debating among ourselves at the moment.

I happen to think that information collection, in and of itself, is what we ought to be doing. We ought to be getting information that people agree is objective and neutral and let the good sense and good judgment of our beneficiaries drive the market to reward plans that perform better.

But I also think that over time, not only in the managed care sector but in Medicare generally, we're going to have to look at the continuation of what is essentially an any willing provider policy in all aspects of the Medicare Program, as to whether that's prudent from the point of view of the government's ability to provide high-quality services at a price we can afford. That's a broader issue perhaps for a separate discussion.

Chairman THOMAS. We're coming back to a discussion we often find ourselves in—and I apologize to the gentleman from Nevada—and that is, if we had some ability to measure or determine quality, we could pick the ones that were appropriate and the ones that weren't. It's just that if, in fact, we're paying for product—and we are, to the tune of billions of dollars—and these folks are collecting data which is currently primarily looked at as proprietary, which allows them to do a good job, I would like to know whether or not we're paying more than we should. Computerized patient records, with due concern for the privacy of the patient and the doctors, I think would allow us to be a more prudent purchaser and begin to develop the kind of outcomes, procedures and guidelines that will let us pass judgment perhaps more in a scientific way than the way we do it now, which is more art.

So I know you're working on that as well. But to me, those are some real keys, to allow us to go back into the marketplace. The 50-50 rule is about as crude as you can get, and I think we have the capability, frankly, which I believe the private sector has, and is currently using this capability that we simply have not tapped into in the way we should, given the amount of money we pay for the product that we receive.

The gentleman from Nevada.

Thank you very much.

Mr. ENSIGN. Thank you, Mr. Chairman. You can horn in on my time any time you want.

I have a couple of questions for you—one, just kind of philosophically—and that is that HCFA has the authority the Congress has given it for patient protection under managed care. How much authority do you think is adequate authority to provide the consumer protections necessary under current law? Do you feel HCFA has the necessary authority, and if that is the case—why do we need some of these other bills?

Mr. VLADECK. Well, we do believe our authority is adequate. In order to be able to go back to the office, permit me to say that it

is not clear whether our resources to exercise that authority are adequate.

But I think most of the other legislation, in fact, has been focused to a considerable extent on non-Medicare, non-Medicaid enrollees, whereas the situation in the private sector is much more mixed.

Now, again, that regulatory authority belongs largely to the States. Some of the States are doing an absolutely excellent job, but many are a little behind the curve in that regard. I think some of the concern at the Federal level really has to do not only with bringing everybody up to a reasonable standard, but some of the "level playingfield" issues, as more and more employers are purchasing on a national basis, as people change jobs from one community to another.

I think it's fair to say that we think it would be a good thing if every American with health insurance had a set of protections as good as those that Medicare beneficiaries have, or should have, as we use our existing authority more effectively.

Mr. ENSIGN. Let me first of all share some things with you. I had a hearing in Las Vegas and brought forth providers, individual physicians, women that had had mastectomies, a representative of people who had actually counseled women that had had mastectomies. I thought it was a fascinating, emotional hearing.

First of all, many of the doctors were not aware of what the patients were going through, which I think is very commonly the case, simply because patients don't share with their doctors a lot of times. A lot of patients felt they were, in fact, maybe discharged early. It was an enlightening hearing for me, informationwise.

But I think it was virtually unanimous, that everybody who testified that day did talk about that they did not want to see it mandated as a particular time period, that the time period itself should be left to the doctor and the patient, and to allow that relationship to continue.

First of all, some of the things that were brought up were, as technology changes, and once you've written something into law, and now you're mandating the practice of medicine based on law, when technology changes, laws don't change as fast as the technology can change. That is some of the concerns I have with some of these bills out here. Being in the practice of medicine myself, it just seems to handcuff the way technology can go forward.

Mr. VLADECK. We believe that, in fact, the issues of quality of care and of physician and patient decisionmaking, under the right kind of circumstances, are something that should not be the subject of detailed legislation or of detailed regulatory oversight on our part. That was part of the message we were trying to convey in our communications about mastectomies.

I think it is one of the reasons the administration has said—and I think within the next few weeks you will see substantially more activity on this front—we need to create some kind of mechanism, a commission or something of that sort, to talk about the general rules of the road, or general guidelines, general policies, that ought to be applied to all health insurance and health benefits. These guidelines ought to apply regardless of whether it's managed care or not, to protect the interests of patients, to protect the appro-

priate professional autonomy of physicians, without getting into a micromanagement in which, frankly, some health care plans have engaged, and which neither the government nor the plans should be doing.

But we do believe those issues ought to be addressed at a "rules of the game" level, rather than mandating so many days per diagnosis.

Mr. ENSIGN. We don't get a chance to talk to you too much up here, and this is totally off the subject we're talking about today. This has to do with something I really haven't been able to find an adequate answer for.

I have held a lot of townhall meetings on Medicare and the Medicare proposals last year, and senior citizens bring this to me all the time. We always hear about fraud, and a lot of the fraud seems to be more a perception than anything. Surely there's abuse, there's waste, and there's all that in the system. But senior citizens constantly bring to me in those townhall meetings—probably 70 percent of the ones who come to those townhall meetings bring a copy of their bill from the hospital. I understand the DRGs and some of the things that are happening there, but they are billed for things that never get done.

Is it a requirement that HCFA has for hospital billing that is a different requirement than the State has? Is there any way to fix that so we don't continue to basically mislead the public into thinking their Medicare is being ripped off when it necessarily isn't?

They call HCFA, and I'm sure the person sitting down there at HCFA doesn't want to have to explain the way the whole process works. So they say, "What do you care. Medicare is paying for it anyway." Now this person thinks he has an uncaring bureaucrat that doesn't care about the system at all when, in fact, it's just a long process to explain.

Mr. VLADECK. I haven't looked at that particular problem in a couple of years. I can tell you that I first encountered it in the State of New Jersey in 1980, where it was exactly the same problem. We haven't solved it in the last 17 years.

I understand the problem exactly. It shows how little progress we've made in the modernization of hospital cost accounting in the last 17 years. But it is certainly worthy of a revisit, and that's something we would be interested in discussing with you.

Mr. ENSIGN. Is that something that maybe we can do, as this Medicare reform proposal goes through this year?

Mr. VLADECK. We will take a look at it and contact you, Mr. Ensign, within the next few weeks.

Mr. ENSIGN. OK. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. I'm surprised you didn't conclude that medical savings accounts would solve that problem.

Mr. ENSIGN. Well, I thought that was so obvious that it didn't need to be mentioned, Mr. Chairman.

Chairman THOMAS. I have discovered over the years that a lot of folks have to belabor the obvious and it is still not obvious.

Mr. ENSIGN. That's a good point. Then medical savings accounts would really resolve that problem. [Laughter.]

Mr. VLADECK. I personally think that exacerbates it. [Laughter.]

Chairman THOMAS. Does the gentleman from Nebraska wish to inquire?

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Vladeck, I wanted to find out how we're doing on the competitive pricing demonstration that is getting ready to be launched in Denver. Are we on schedule to launch it, or has it already been launched?

Mr. VLADECK. We have announced that we're going forward. We have had a number of meetings with beneficiary organizations, with public officials, and with the plans. I think we met with the plans most recently on Thursday or Friday of last week.

We are on track to set rates through a bidding process, effective January 1 of next year.

Mr. CHRISTENSEN. How are you doing that? Can you go through that with me? How are you doing that, as far as the demonstration project?

Mr. VLADECK. The bidding process we've proposed is essentially as follows. We are going to establish essentially two benefit packages. One is the basic minimum Medicare benefit package that's guaranteed to all beneficiaries, and the other is a description of what is effectively the prevailing dominant package in the Denver market at the moment, where the overwhelming number of beneficiaries in HMOs have elected plans with a somewhat richer benefit package.

We will then ask each of the plans to submit bids for each level of those performances for the basic benefits and then for the standard benefit package. Once we receive all those bids, we will then look at the information they provide and set a government price, a single price which we will pay all of the plans that continue to participate in the Denver market.

Those plans that have costs below the price will be able to offer additional benefits or lower their premiums accordingly, and those that are above the price we will have to either charge them a premium or adjust their benefit package. We will do this in time so that when they go into the market for the 1998 rate year, they will be able to inform beneficiaries of what they will be offering at that price.

Mr. CHRISTENSEN. Within this demonstration project, is there anything that's going to be addressing the PSOs and PSNs issue or not?

Mr. VLADECK. No. These will just be plans who are eligible for Medicare under existing law.

Mr. CHRISTENSEN. Concerning that, there have been some people who have raised the issue on regulations, as far as the PPOs and PSNs. Is HCFA looking at any of the regulations as far as the current process we're looking at for PSOs?

Mr. VLADECK. We have contracted, or are in the process of contracting, with about seven or eight PSOs, PSNs, under our Choices Demonstration Program, which is another demonstration program. In each of those instances, we have had to work through with the licensure authorities in those States the licensure status of those entities. We have drawn on that experience as we've worked on the PSO provisions in the President's bill.

I think it's fair to say we have a set of provisions that would encourage the entry of PSOs into the Medicare Program. I think it's also fair to say that they are not entirely what the hospital and physician community would have sought in that legislation. We think we strike a balance of encouraging PSOs without being unfair to existing plans and competitors in the market. That's what we're trying to get in the legislative proposal.

Mr. CHRISTENSEN. OK.

Recently, the Office of Inspector General has issued several reports critical of the appeals process for beneficiaries enrolled in Medicare HMOs. In your judgment, are the proposed regulations and the concerns raised by the Office of Inspector General report legitimate? Are you looking at that, and what have you done concerning the report?

Mr. VLADECK. We think the concerns are very legitimate and we have begun to address some of them. Frankly, together with the initiative and financial resources of the Inspector General, we prepared an educational booklet for beneficiaries on the appeals and grievance process that I think will address their recommendations about beneficiary education. We have already printed several hundred thousand copies.

We think most of the rest of the Office of the Inspector General's recommendations are, in fact, addressed in our new rules, which we hope to publish for comment within the next few weeks.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Chairman THOMAS. Does the gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. Thank you, Mr. Thomas.

Bruce, let's go back for a moment to the PSOs that Mr. Christensen was talking about. What does the President provide in his budget as far as regulation and solvency standards for PSOs? This is an issue we had before the Subcommittee and Full Committee last year, and it's something that I agree with, although I also agree the Governor from my State of Wisconsin and Insurance Commissioner—that the States should regulate these new entities, which I think will be good for competition.

What is the President's view on that?

Mr. VLADECK. Let me say that we contemplate eventually establishing a system of State regulation for PSOs. What we are proposing would establish a set of minimum Federal standards for all managed care plans, with some special provisions in the first few years after enactment of the legislation for PSOs, but then gradually the regulatory responsibility and authority would be given to the States, to the extent that the State's standards met or exceeded the Federal standards.

Mr. KLECZKA. Who controls the HMOs? Who regulates HMOs today?

Mr. VLADECK. Well, again there is the same kind of bifurcation. There is a set of Federal standards, but most of them can be met by State licensure. We have some additional standards that we separately identify and evaluate, and it is very much that model that we would like to generalize to the broader range of managed care plans with whom we want to do business.

Mr. KLECZKA. OK. I think that's something we have to discuss as a Subcommittee, and also as individuals, with HCFA.

Mr. VLADECK. On the issue of solvency, we do believe the concern that the PSOs have raised is valid, that certain assets that are utilized in the actual delivery of health services ought to be evaluated a little bit differently than more narrowly defined financial assets.

Mr. KLECZKA. And they're talking about excluding what type of an asset?

Mr. VLADECK. Well, it's really not so much exclusion as it is a question of how you evaluate an asset, such as a health care facility, for purposes of solvency requirements, and the extent to which some conventional solvency analyses might underestimate the true potential utility of that asset in providing continuing health services.

So we are accepting the argument that there ought to be alternative measures of solvency when assets that are used in the actual delivery of health care are involved.

Mr. KLECZKA. I think the best beneficiary protection can be had with State solvency rules, but I guess that debate will continue on.

You indicate you are in favor of PSNs and PSOs, in an attempt to get these organizations into the rural areas. Do you see that that might move faster than HMOs expanding out into the rural areas? Because we have legislators who might not be here today who voice that concern repeatedly, and it is one, as we look at the data, that is surely evident.

Mr. VLADECK. I think you need a package of things to increase the availability of managed care in rural areas. In many instances, I think PSOs will be the vehicle through which managed care comes to those communities, but I think you have to fix some of the payment problems at the same time. I think addressing the impact of the 50-50 rule in rural areas has to be done at the same time as well.

If you do those things, then I think we will see a very substantial growth in Medicare managed care in rural communities.

Mr. KLECZKA. Well, the payment problem, the per capita payment problem, is one that Wisconsin is experiencing, also, and that formula fight, like the highway formula fight, will continue for some time.

Let me turn for a moment to the home health care issue. We've had a couple of hearings on it. We find it's a rapidly growing area of reimbursement; we're told there might be some excesses in the actual billings. But, nevertheless, the bottom line, Bruce, is, in my opinion, if we can, in fact, keep people in the home, versus another setting like a skilled nursing facility, I would have to think the taxpayers save money in the long run. However, we're seeing, because of the growth, that that might not be true.

What is your experience or your knowledge on that? Even though the thing is exceeding all bounds, are we still saving some dollars there, versus another type setting?

Mr. VLADECK. No. I think it is a sad, but true, fact, which makes the policy dilemma much more difficult, that without the Medicare home care, most of the people now receiving it would be in the community receiving no services, or no formal services. These are folks who, by any measure, ought to be getting some degree of services because of the degree of disability and isolation they experience.

Whether the services they ought to be getting are those for which we're now paying is another question.

Mr. KLECZKA. That's a debatable point.

Mr. VLADECK. In the absence of Medicare home care, these people would be going without any services.

Mr. KLECZKA. I don't know how you can draw that conclusion. I would think the opposite, that if, in fact, that care would not be available in the community, these folks would opt to go to a skilled nursing facility, which as we know by their costs would be much more expensive.

Mr. VLADECK. Well, our experience with home care over the last 20 years is that there is a substantial excess of folks in the community with serious problems that don't require acute hospitalization, and the one advantage from a programmatic point of view, or a financial point of view, of facilities-based services, is that you have a fixed supply; you have a constraint in how much service you can supply that is produced by the number of beds, which is why so many States have sought for so long to limit the supply of nursing home beds in their States.

We have never developed utilization controls on the home care side nearly as tight as the bed constraint on institutional long-term care services. In the absence of such a constraint, it has proven very, very difficult to limit the availability of the service because there are lots of people out there with lots of need. The question is, If they weren't getting the services, would they be in nursing homes? No, because the nursing homes are all full.

Mr. KLECZKA. OK, because of the debt capacity limits. Well, I know we're going to be addressing the abuse questions in home health care. I just hope this Congress doesn't go too far and curtail the service to the point of, under the guise of abuse, that people aren't going to get the needed care, as you correctly point out here.

Mr. VLADECK. I think the point is that if we are going to significantly reform the home care benefit under Medicare—and I think we need to—that will increase the importance and the urgency of our doing something more systematic about community-based long-term care, whether through a combination of Medicare and Medicaid Programs or other mechanisms as well.

The Medicare home care benefit can't and shouldn't substitute for the absence of the long-term care services we need in most of our communities, but if we cut back on Medicare home care to the extent we probably should, we will make the shortage of long-term care services even more pressing.

Mr. KLECZKA. Thank you.

Chairman THOMAS. Just briefly, Bruce, partly in response to my friend from Wisconsin, I recently went through a rural operation in which there was 1 hospital and 34 doctors and they wanted to form a provider-sponsored organization, and we were able to work through the antitrust waiver by creating a third party through which all of the financial relationships went. It was a bit of a hassle, but everyone, including the community, seems to be pleased with it.

It is the solvency question. We wrestled with it in our Medicare proposal. I do think the field of knowledge is growing relatively rapidly. I have been promised, I think, by the National Association

of Insurance Commissioners, that within 6 months they will give us some empirical data about this business of, if there is a distinction, if there really is a difference on the solvency.

It's also a concern by the HMOs and others, and we're fighting a 25-year battle all over again with the new structure, with a new group of folk, that, in fact, "I had to do it that way walking 20 miles through snow, barefoot, to school, and anybody else who comes along has to do the same thing. It's unfair to have a one-stop shop at the Federal level—"

Mr. KLECZKA. Were both ways uphill, by the way?

Chairman THOMAS. Both ways uphill. [Laughter.]

Of course, the key to that is the only reason we would move to a Federal level, as Bruce said, is to facilitate the creation of these because of intransigent State structures that are not doing the reasonable thing. To the degree we can be convinced the standards are appropriate out there, and the States would be doing the reasonable thing, there would be no reason whatsoever not to have it go through the same process at the State level. I just think we're 6 months to 1 year away from some fairly comfortable information that will let us make that decision.

The other thing I have a concern about is that I would love to see the growth rates in HMOs in the private sector, circa 1990 or 1985, in terms of what they thought the rates were going to be in 1995, 1996, 1997, or the year 2000. I would be surprised if I found someone who thought that 75 percent of the people who got their health insurance from their employer would be in managed care. I think the rapidity with which the movement took place surprised a lot of people.

One of the reasons was that the employers were driven by one of the fundamentals, and that was cost, and they had to make choices. It's less so in this structure. But I think to a certain extent it was also informational. Once people were somewhat educated about what they were giving up; i.e., ultimate choice, and there were some savings to be made that the educational informational route was one that helped speed it up.

I'm concerned about our basic failure in terms of informing beneficiaries of availability—recently, the failure to even include risk options to the beneficiaries. I know you have initiated the handbook, and I still don't know why you can't get decent merged software, so that where there clearly are two or more people living at the same residence, you don't send a book to everybody. But that's a different subject and I won't go into that.

But if you will look at the average cost of the private sector, in terms of education and information to the retirees, they're talking \$75 a head sometimes to get that information to them. So I am very concerned about our failure to be aggressive in the education and information area.

Here's the question. If we are, couldn't we really affect those curves that you have on the chart? I don't know how significantly, but the answer has to be yes. I just don't know how to—

Mr. VLADECK. Let me say two things. First, that's why we think it's so important—and we differentiated this from the 1995 legislation—that there be not only a requirement for information services

in the legislation, but a financing mechanism for it, because it isn't going to come out of domestic discretionary accounts.

Second, I would say that if you look at the private sector, it can be argued that the major reason for the much greater rate of growth is not a function of better information; it's a function of the fact that that private sector enrollment happened wholesale, not retail. That is to say, the overwhelming majority of people in the private sector in managed care plans did not elect to go into managed care plans. Their employers elected it for them. For any situation in which individual consumers are choosing, I think the rate of change is going to be slower.

I think, given our sense about the Medicare Program and the nature of the entitlement, we feel very strongly that it should be a matter of individual choice. It does mean the change will take place less quickly than it would if we were mandating choices.

Chairman THOMAS. I agree with you, but at one time the concern was that people coming out of the private sector, if we pushed managed care in Medicare, would be moving in a system that was foreign to them. We're going to have exactly the opposite structure because, whether wholesale or retail, of what has occurred in terms of the place of work as they move into the rocking chair. They're going to find a foreign system available to them called fee-for-service if we don't move forward.

Mr. VLADECK. That's absolutely correct.

Chairman THOMAS. So whether it's wholesale or retail, what they're familiar with in the delivery system is becoming far more different between the people who are retiring now in exactly the opposite way that we had anticipated just a few years ago.

Mr. ENSIGN. Would the gentleman yield just briefly on that?

Chairman THOMAS. Surely.

Mr. ENSIGN. I was just curious on your comments about not being as fast because the consumer was making the choice. In the State of Nevada we're seeing a dramatic shift to Medicare managed care. People are making choices and they're moving there rapidly.

Mr. VLADECK. I think in some parts of the country that curve is very, very conservative. I think in other parts of the country it's optimistic. It's a function somewhat of what the plans are. Health care markets are different in different communities, and you're also in a particularly fast-growing community, to which—

Mr. ENSIGN. But percentagewise they're growing.

Mr. VLADECK. I understand, but which people are resettling and, therefore, not coming with 30- and 40-year relationships with fee-for-service doctors, which I think has something to do with it.

You also have some very sophisticated, some very well-established plans in your community. Metropolitan Las Vegas, as it is in many dimensions, is particularly fast growing in Medicare managed care, but there are other communities throughout the country that are seeing those rapid rates of growth.

On the other hand, there are other communities where we've had a lot of Medicare managed care for a long time, where they have pretty much plateaued. So every market is different, which is the one generalization I can make.

Mr. ENSIGN. Thank you.

Chairman THOMAS. Just let me say that one of the reasons they want to push PSOs is that, as you indicated, with the doctor-patient relationship of 30 to 40 years, when the doctor is moving into the managed care structure and the patient follows.

Mr. VLADECK. Yes, sir.

Chairman THOMAS. Instead of having the patient move with all of the trauma involved. That's why it's also an—

Mr. VLADECK. Absolutely.

Chairman THOMAS. Does the gentleman from California wish to inquire?

Mr. STARK. Yes. I wanted to talk a little bit about your regulations for appeals. I think you testified that maybe those needed to be tightened up; is that right?

Mr. VLADECK. I think they need to be systematically rewritten.

Mr. STARK. Yes. We're going to hear later—and this is why I wanted to suggest to you where the beneficiaries are being "done in." I think in your regulations now, as I read this, it can take 120 days to get out of the plan if the decision tree was "no" at each juncture.

Now, arguably, you could do it in a day or two, I suppose, if there are any humane managed care plans who care about the patient over profits. But if there was one, you could probably get through it in a day or two.

I am informed here that the AMA is going to tell us that 80 percent of the doctors in a survey they did in 1995 report serious problems in referring patients to specialists. For you doctors in the audience, I've got to tell you more is coming, because we're going to be informed that the managed care plans now are going to computerize the referral process. They really don't need the doctor. You're going to push a series of buttons, typing yes or no on the computer to the answer of a series of questions, and the machine is going to pop out and say you get a referral or you don't. What they don't tell you is that, at the other end of the wire, there is some five-dollar-an-hour person sitting there with a switch, turning it on and off, and they always turn it to "no" regardless of what the doctor pushes on the computer, but you're not going to know that for a while.

Then they also are going to have "virtual M.D.s," so you can get on the Internet, put your headphones on, put the mask over, and if you feel like vomiting, you'll feel it more, and then the machine will say "No, you don't need to go to the emergency room."

A third thing—and this happened to me while I was getting my car washed. You take your credit card out and put it through the swipe and they're going to tell you whether you're going to get referred or not.

Now, I'll leave it to the doctors when they testify to say whether that will help them in the practice of medicine. But should we not have some symmetry between the amount of effort and time that goes into the approval or denial of the referral and the appeal? In other words, if they can sit there and push the button, then it's denied—and let's say the whole process takes one-half hour—how about requiring that my appeal doesn't take more than 1 hour, so I don't have to schedule another appointment—what's sauce for the goose, it seems to me, should be sauce for the gander. Besides

which, if you take 120 days, you could die, which saves the HMO a lot of money. That may be, it seems to me, too long where there's a life-threatening referral.

So I would hope you are not going to continue to allow the treasurers and the "bean counters" in these managed care plans to get the rate of not only the disenrollment envisioned but disenrollment of doctors who don't like doing this, either, but to require some fairness.

Understand that the patient may be limited in knowledge, is probably in a situation where they're scared and unable to be as rational as a computer, are very powerless, and probably have to get back to work or don't have any money. So if you're going to tilt this process, I would hope you would tilt it in favor of the patient.

For example, make the HMO do the procedure, and then drag out whether or not the patient has to pay the HMO any money back, drag that out for years, try that for a while, rather than us pay the HMO and let them put the person off.

The doctors have always complained about this Subcommittee, Mr. Chairman, doing "cookbook medicine," but we have never dragged out our laptops and started pushing buttons over the Internet to let America On Line decide for us what our next step in the process would be.

I hope your regulations will be a lot shorter than 120 days.

Thank you. And thank you, Mr. Chairman.

Chairman THOMAS. I did want to buy one of those rational computers. I want to know where they are.

Mr. STARK. I thought we could get that under our House Supply.

Mr. CHRISTENSEN. Mr. Stark, you don't have to worry about America On Line. All you get is a busy signal. [Laughter.]

Mr. STARK. Is that a no or a yes; that's all I want to know.

Chairman THOMAS. Thank you very much, Bruce.

Mr. VLADECK. Thank you.

Chairman THOMAS. I assume we'll see you again soon.

Mr. VLADECK. I imagine so.

Chairman THOMAS. Come on back with \$18 billion in your pocket and we'll talk. [Laughter.]

For our next panel, it will be my pleasure to introduce three of the four, and I will defer the fourth introduction to a colleague of mine who serves on House Oversight, and anyone who serves on House Oversight deserves any perks of the business we can offer to them.

The first member of the panel is Stanley B. Jones, who is chair of the Committee on Choice and Managed Care.

The second member of the panel is Margaret O'Kane, president of the National Committee for Quality Assurance. The third member of the panel is J. Randall MacDonald, senior vice president, Human Resources and Administration, GTE Corp.

For the fourth member of the panel, I will defer to the gentleman from Ohio, Mr. Ney, who tells me he cut your first check. So I will leave it to him to introduce Mr. Randall.

Mr. NEY. Thank you, Mr. Chairman. I assure the Chair I won't take you down "Buckeye Memory Lane," as I did in House Oversight with John Kasich. But I do want to introduce Dave Randall, who is the deputy superintendent of insurance. He came from Cleveland, Ohio, and got his first honest paycheck in the State Senate, and he actually worked for me when I was chairman of Insurance and Banking there.

I do want to note that he really helped to develop laws that actually cut costs in Ohio, and also in his current position, was foremost 3 to 4 years ago in developing House Bill 478, which was one of the premier bills to get more people insured and to really change the way we do business in the State of Ohio.

He is extremely knowledgeable and is used to being badgered, because he worked for us in the Senate. So I just want to welcome our deputy superintendent of insurance and a friend of mine, Dave Randall.

Chairman THOMAS. Mr. Randall, it's a pleasure to welcome you, and despite the misdirection of your early employment, I am pleased to see that you corrected yourself and that you're here before us.

As I tell any guests, the written statements you have will be made a part of the record, without objection, and you can address us in any way you see fit on the subject matter.

Mr. Jones.

STATEMENT OF STANLEY B. JONES, DIRECTOR, GEORGE WASHINGTON UNIVERSITY HEALTH INSURANCE REFORM PROJECT; AND CHAIR, COMMITTEE ON CHOICE AND MANAGED CARE: ASSURING PUBLIC ACCOUNTABILITY AND INFORMATION FOR INFORMED PURCHASING BY AND ON BEHALF OF MEDICARE BENEFICIARIES, INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES

Mr. JONES. Thank you. It's a privilege to be here.

I am here as chairman of an Institute of Medicine Committee that is studying how to help Medicare beneficiaries choose. I believe you have in your packet a copy of the findings and recommendations that our committee has thus far published. I just want to say a few things to put them in context.

First, you here in Congress, like me at the university, and millions of other employees across the country, have to choose among health care plans. We all know there are both opportunities associated with it, and some headaches. It's not easy to choose.

It is important to step back and realize that choice is much, much harder for Medicare beneficiaries and the stakes are much higher than they are for us. In the first place, they're likely to have more choices, and a wider range of choices, than we have available to us.

In the second place, they get far less help and less information to make these choices than we get from our employers. In fact, Medicare in this regard is way behind the curve, especially way behind the large employers in our country. Indeed, several members of our committee who are familiar with the state of the art in this respect suggest it is primitive.

In the third place, many Medicare beneficiaries have chronic conditions or disabilities that make it harder for them to do their research and make hard choices. This also, incidentally, makes it very important for them to choose carefully, lest they pay more out of pocket for their care, or they get fewer services, because of a bad choice.

Mr. Chairman, we are, in fact, right now confronting beneficiaries with a more difficult choice than employees make. We're providing them with less help in making it, and we're asking them to do it at a time in their lives when their need is very great and many are easily misled.

Is this any way to run a railroad? The Institute of Medicine Committee, whose membership you will see on the list, felt not. We all agreed we need to take major steps to improve the help we give beneficiaries if the choice of health plans is to work in Medicare.

Most critically, we recommended more concerted effort by government to inform beneficiaries. We think government should match for our elderly and disabled the best practices of our leading employers.

For example, we recommend creating a customer service and enrollment center for beneficiaries, whose job it is to research what beneficiaries need, use the latest computer and communication technology to offer them assistance on the plans and providers in their area, and give them personal, one-to-one advice on the phone. All of the research and papers we had presented to us suggested this is what works best, especially among the elderly in our population.

The technical people on our committee believe this can be done. It was the committee's recommendation, incidentally, that this major activity be carried out by a private, independent entity under contract to the government. We lay out in the recommendations in some detail the kind of information people need and that research suggests people can use in making choices.

Earlier, the point was made about putting data in usable form. That's the key to the whole situation. There is, in fact, an enormous amount of data available to the public for Medicare now, but putting it in a form that people can use for choosing is a different matter.

This is going to cost money, and it's important that you understand the scale and necessity of this effort. We suggest in our report that, because of the cost, and because it's so easy to cut administrative costs in the tight budget balancing process we face, we need to set up a levy of some kind on insurance premiums and set these dollars aside so there's a consistent funding for a major effort to inform people. We call this an "Informed Choice Fund."

Earlier you were asking questions about a string of issues which you will find specifically addressed in our recommendations, including annual open seasons, which we recommend, including Medicare supplemental plans in that open season, requiring Medicare supplementals to accept all applicants without regard to preexisting conditions, and requiring plans to standardize information in the way they present themselves and benefits to beneficiaries.

We suggest rules about door-to-door marketing, and outgoing telephone marketing, and we also argue that agents should make

clear their commission to beneficiaries when they're approaching them. Now, insurers are nervous about that because they think it will make the beneficiary skeptical; and we suggest that, in fact, in a competitive marketplace, the beneficiary needs to be skeptical.

Finally, let me suggest that our committee believes we are, in fact, in uncharted waters in this choice process that we're embarked on. We can't be certain, based on the research that's available, whether beneficiaries, as a group, will be able to choose well in their own best interest. We don't have grounds to be certain. So we need to be cautious, and we think that suggests three things.

First, we need to maintain the traditional Medicare Program for the foreseeable future in a form that makes it a reasonable choice for those who are afraid to choose, or who make a mistake and want to come home to a safe harbor. At present, the Medicare Program seems to me, personally, like something of a slow whale surrounded by more athletic sharks who are able to bite off tender chunks of its enrollment by offering them genuinely better deals.

Second, we need and are embarked on an improvement of the grievance and appeals procedures. You will find a lot of support in our recommendations for the things you're talking about.

Finally, we need to study and restrict practices that might provoke a physician or other provider, in the words of the committee, "to evade their ethical responsibility to provide patients with complete information about their illness and treatment options, what, to the best of the provider's knowledge, the patient's plan covers, and which health plans in the provider's experience would provide the best range of services to the patient in question."

This goes way beyond gag rules. We're talking about a fundamental relationship between the payer, the provider, and the patient. And we're in new and uncharted waters in this area. We need to study it, understand it, and we particularly need to know that chronically ill elderly beneficiaries are very dependent on their physicians' advice and candor and have no choice but to trust them. We need to protect them in that area.

Thank you.

[The prepared statement and attachments follow:]

Statement of Stanley B. Jones, Director, George Washington University Health Insurance Reform Project; and Chair, Committee on Choice and Managed Care: Assuring Public Accountability and Information for Informed Purchasing by and on Behalf of Medicare Beneficiaries, Institute of Medicine, National Academy of Sciences

The testimony I am providing is based on the recommendations of the August 1996 Institute of Medicine report, Improving the Medicare Market: Adding Choice and Protections, which I chaired. A quick glance at any day's headlines will tell you that the Medicare program is being transformed. The change underway is similar to changes sweeping through the rest of the health care system. Even without the action of Congress, the 31-year-old Medicare program is being restructured.

Chief among the changes is a major movement of Medicare beneficiaries away from the current fee-for-service system, in which the majority of the Medicare population continues to receive care, into a broad range of managed care and other delivery options. An average of 80,000 Medicare beneficiaries each month are switching from the traditional Medicare fee-for-service system to some form of managed care.

Our committee found that many elderly are making these new choices without enough information to judge which option is best for them, what the plan they choose will actually cover, or how the plan will operate. We focused on understanding the needs of the Medicare population, and on identifying ways that the federal government and private insurers can help them navigate these uncharted waters.

Our recommendations are based on a simple premise: that better informed beneficiaries will make better choices, and ultimately will help create better health plans. We believe that enabling these beneficiaries to make informed choices among competing health plans is a critical step toward assuring that plans are responsive to beneficiaries' needs.

It is vital that the Medicare program be operated in a way that enables beneficiaries to trust their health plan, to trust their physicians, and to trust that the information they are provided is relevant and of high quality. Many in today's elderly population have not had experience in making choices among multiple plans, even before they retired. In addition, many in this group are very old, frail, disabled, or have chronic health problems that make their choice of health plans and providers particularly meaningful. We found that Medicare beneficiaries don't have the information and experience they need to make the choices demanded of them, and many feel a high level of apprehension and mistrust about change. And many are confused by a political debate that links the notion of choice and managed care with federal budget cuts. Further exacerbating the problem is the fact that most health plans have short-lived experience marketing and providing comprehensive services to this population.

To help build an atmosphere of trust and greater confidence, our report recommends that all health plans approved for marketing to the Medicare population including the whole spectrum of new managed care options, as well as Medigap plans and traditional Medicare should be required to meet a series of benchmark standards that assure quality and service. These standards include the requirement for an annual open enrollment season to enable beneficiaries to more easily compare the true value of all options; guaranteed renewal of coverage with no exemptions for people with pre-existing health problems; providing beneficiaries with information that is specified by the federal government to assure informed choice; and meeting quality certification requirements comparable to those already developed by national private accreditation organizations. The new HEDIS 3.0 requirements announced by HCFA in October are a step in the right direction. In addition, our report says that health plan guidelines about how to enroll, dis-enroll, and file for appeals or grievances should be made easier to access and use.

We believe that Medicare beneficiaries should be assured that any plan marketed to them meets these benchmarks, in the same way consumers who purchase a new car assume that basic safety standards are being required of automakers. The choices made by beneficiaries in their newer, more active role will then drive plans to exceed the benchmarks.

Our study found that the current information available to Medicare beneficiaries lags far behind the kinds of assistance provided by progressive private employers to their employees. The committee recommends unprecedented efforts to develop and provide information, including the establishment of a new private information service, to educate the public about Medicare's coverages, costs, and purpose, and to provide broad and objective information about new care options. We call for creation of a national customer service center, where one could reach a representative who has access to on-line information. Toll-free telephone service, online communications, town meetings, newsletters, and multimedia techniques should be used not only to provide information, but also to track complaints, grievances, and appeals, and to report this information to beneficiaries annually and to health plan chief executive officers monthly.

We also recommend further experimentation with private "choice facilitating organizations" whose purpose would be to assist beneficiaries in understanding and choosing among plans. And we call for prohibiting health plans from conducting door-to-door marketing and unrequested phone solicitation.

Finally, we recommend preserving traditional Medicare as a viable option for the foreseeable future, as an essential step toward ensuring the trust and confidence of Medicare beneficiaries. It is especially critical to preserve this "safe harbor" for beneficiaries whose experience with managed care is far more limited than their younger counterparts.

We are clearly at the very beginning of what will be major changes in the Medicare program. As we say in the report, much of this change represents uncharted waters, especially for those currently enrolled in Medicare. Making the right choice of a health plan is extremely important to older Americans. Having the information, education, and tools to measure the quality of a health plan is imperative to assist seniors in this choice. Arming Medicare beneficiaries with safeguards as well as understandable information will help them take advantage of the opportunities that come in an environment of expanded choice.

Thank you for the opportunity to present our committee's recommendations. I look forward to answering your questions. Following this text is an excerpt from our August 1996 report fully detailing the findings and recommendations of our committee.

Excerpted from Improving the Medicare Market: Adding Choice and Protections ©1996, National Academy Press

Findings and Recommendations

RECOMMENDATION 1

All Medicare choices¹ that meet the standard conditions of participation and that are available in a local market should be offered to Medicare beneficiaries to increase the likelihood that beneficiaries can find a plan of value. Traditional Medicare should be maintained as an option and as an acceptable "safe harbor" for beneficiaries, especially those who are physically or mentally frail.

NUMBER AND TYPE OF HEALTH PLANS TO BE OFFERED

Findings

Medicare beneficiaries are currently offered traditional Medicare, Medigap policies, and, in many areas of the country, a growing number of alternative health plans. New initiatives in Medicare and proposed reforms of the Medicare program would broaden the number and range of alternative health plans offered.

For most Medicare beneficiaries the range of options and the responsibility for choosing among those options are likely to be significantly greater than those currently available to a large percentage of the working population. Unlike private employers, which have the power to limit the number and types of plans offered, current Medicare practice and proposed reforms would allow any plan that meets specified conditions of participation to sell coverage to Medicare beneficiaries.

Although the committee was cautioned that a large number of choices may increase the confusion for Medicare beneficiaries, it may also increase the ability of Medicare beneficiaries to find a plan that they like, for example, a plan that includes their chosen doctor, that offers valued additional coverage, or that provides convenient access to services. The fear of not being able to continue to see a chosen caregiver has been shown to be a major reason why elderly individuals are reluctant to move into managed care arrangements. Competition among a larger number of health plans will likely produce more innovation on the part of health plans to find ways to be more responsive to the wants and needs of beneficiaries.

The committee also was concerned that limiting the numbers of plans, beyond requiring them to meet benchmark² conditions of participation, would raise policy and political issues, given the size of the Medicare program and the proportion of total U.S. health care revenues that it represents. Setting limits would have a vast impact on competitors and the market as a whole.

Subrecommendations

The committee recommends that all Medicare choices that meet the benchmark conditions of participation be offered to beneficiaries. Conditions of participation should be carefully constructed to bear the burden of assuring informed choice by beneficiaries and accountability by health plans for access to quality systems of care. All Medicare choices should have to meet common conditions of participation.

This policy may result in the marketing of plans with limited appeal and small numbers of Medicare beneficiary enrollees over time. The committee recommends that these kinds of plans be tracked over time and evaluated for their potential impacts on risk selection³ and administrative costs and the extent to which they cause confusion among beneficiaries.

¹ For the purpose of this chapter, the term Medicare choices is an umbrella term for traditional Medicare, Medigap insurance, and alternative health plans (including managed care).

² Benchmark is defined as a floor, with the expectation that participating plans would exceed this level.

³ As in other sections of the report, the committee understands the inadequacy and limitations of current risk adjustment methods and recommends that further research be supported in this critical area. In the meantime, however, practical requirements necessitate that available techniques be used to make best-judgment decisions.

THE TRADITIONAL MEDICARE PROGRAM

Findings

Given how little is known about ensuring informed choice and holding health plans accountable for providing quality care to Medicare beneficiaries and given the consequent risks for the beneficiaries, the committee believes that traditional Medicare must remain an option and a safe harbor for beneficiaries.⁴ This option should be at least as good as the existing Medicare program in terms of benefits, beneficiary cost-sharing, choice of providers, geographic access, and other factors.

The committee believes that maintaining traditional Medicare as a choice is critical for allowing large numbers and a wide range of plans to be offered to Medicare beneficiaries. Without the ability to retain the traditional Medicare program as an option and safe harbor, particularly for beneficiaries who are physically and mentally frail, the committee would not recommend widening the Medicare marketplace to the extent that is advocated in this report.

The committee is aware that traditional indemnity plans are becoming a relic for the market under age 65; many fee-for-service plans have been discontinued because of their high premiums, their noncompetitive benefits, and adverse risk selection. Within this environment, special challenges exist for the future viability of the traditional Medicare program. Constraints on Medicare spending are adding new urgency to managing the costs of care delivered in the traditional Medicare program. Maintaining traditional Medicare as an option is likely to be difficult and could require additional costs to government.

The committee was not able, within the time frame and scope of its task, to make the difficult estimates of these potential costs to government or their wider social implications. The committee is mindful, however, of efforts by the National Academy of Social Insurance, the Prospective Payment Assessment Commission (ProPAC), PPRC, and others to explore ways in which Medicare's fee-for-service program can be shaped in the future to make it more efficient and to improve its management and delivery of care.

Subrecommendations

In the framework of the findings presented above, the committee recommends that HCFA, under its demonstration authorities, accelerate its efforts to identify private-sector purchasing and management techniques that can be adopted appropriately for use by the traditional Medicare program as an alternative to price reductions and, when possible, to offer additional benefits to maintain the program's value. HCFA's current development of "centers of excellence" for high-technology procedures seems an example of such an adaptation.

As indicated elsewhere, it is also critical that risk selection measurement and adjustment technologies be improved for use by traditional Medicare and health plans. As improved technology for measuring risk selection is developed, HCFA should study the traditional Medicare program's risk pool relative to those of other health plans and assess whether program funding fairly reflects Medicare's risk profile to enable it to offer a product of competitive value to beneficiaries. The federal government should also study and pilot test ways to pay health plans more fairly for chronically ill beneficiaries to encourage health plans to invest in and market to those beneficiaries.

RISK SELECTION

Findings

It was beyond the scope of the present study to address problems of risk selection among the multiple Medicare choices and to recommend steps to correct for those problems. During its deliberations, however, the committee found that mechanisms to prevent or correct for risk selection are critical to the ultimate success of any system offering multiple health plan choices and that the existing Medicare AAPCC cannot be relied on to achieve success in this area.

The number and range of health plan choices being proposed for Medicare beneficiaries and variations in benefits, premiums, and marketing are likely to greatly increase the potential for risk selection among those offering the various Medicare choices. Since risk selection can seriously undermine the viabilities of the traditional Medicare program and individual plans, it is important that this problem be addressed and controlled.

⁴ The committee defines safe harbor as a program that is financially stable and that remains an option for the foreseeable future.

Ultimately, the committee is concerned about incentives and the capability of physicians with a direct financial interest in a plan to recruit (or avoid) subscribers on the basis of whether that individual is a high- or low-level user of health services.

RECOMMENDATION 2

Enrollment and disenrollment guidelines, appeals and grievance procedures, and marketing rules should reflect Medicare beneficiaries' vulnerability and lack of understanding of traditional Medicare and Medigap insurance and their current lack of trust in important aspects of alternative health plans.

BENEFICIARY ENROLLMENT AND DISENROLLMENT

Findings

The committee found that numerous factors make it critical to facilitate the Medicare enrollment and disenrollment process in an environment of market competition and broader choice:

- Medicare beneficiaries are apprehensive about managed care, the concept of risk, the choice process, and lock-in provisions that would prevent beneficiaries from leaving a plan with which they become dissatisfied after enrollment.
- Many Medicare beneficiaries are poorly informed about traditional health insurance in general and are even more poorly informed about their Medicare choices and the choice process. A considerable amount of beneficiary dissatisfaction, especially among those beneficiaries who are new to managed care, appears to be related to misunderstandings of the basic structure, payment and care practices, and the choice process.
- Some beneficiaries unknowingly lose their Medigap insurance coverage or face a premium increase if they join a managed care plan and later return to Medicare.
- Managed care uses practice protocols and definitions of what constitutes medical necessity and appropriate care that vary from those used by the traditional Medicare program. These differences can result in various types and levels of service for specific illnesses and conditions. It is often difficult for beneficiaries to understand these protocols and their implications for the specific services offered by various plans before enrolling in a plan.
- Many Medicare beneficiaries are disadvantaged in the choice process by physical or mental frailty or by poor vision or hearing.
- Some Medicare beneficiaries who receive their care from HMOs now must enroll in and disenroll from plans as they move between summer and winter residences. The portability of a managed care plan may be further hindered by annual open enrollment policies and lock-in provisions.
- Beneficiaries can be negatively affected by health plan changes beyond their control, such as when their provider ceases to contract with the plan.
- Beneficiaries who make misinformed choices can be hurt financially or clinically, or both. The committee is most concerned with minimizing adverse clinical outcomes, but would err on the side of greater leniency in allowing beneficiaries to leave a plan with which they are dissatisfied.

Subrecommendations

Given the findings presented above, the committee recommends a transition period of 2 years from the time that legislation is implemented during which the federal government would continue the current option of permitting monthly changes of enrollment by Medicare beneficiaries. After this transition period, enrollees should be locked into the plan that they have selected for 1 year, with the following exceptions. All enrollees will have 90 days from the time of enrollment in a health plan to disenroll and enroll in traditional Medicare, and newly entitled beneficiaries and beneficiaries who have never before chosen a health plan (i.e., those who have been enrolled in the traditional Medicare program) should have the prerogative of changing plans or rejoining the traditional Medicare program within 90 days. There is a prevailing sentiment among committee members that the federal government should set limits on the number of times that new health plans' members can change plans. Beneficiaries should be allowed to return to their previous Medigap policy with no additional premium costs and with no restrictions placed on preexisting conditions if they disenroll from a health plan within 90 days and return to the traditional Medicare program.

The committee would like to see the federal government encourage plans to offer adequate out-of-area coverage for their enrollees who reside out of the plan's service area for more than 3 months. This can be achieved through interplan reciprocity or point-of-service options.

GRIEVANCE AND APPEALS PROCEDURES

Findings

The current Medicare appeals process has been shown to be slow and not adequately advertised by HCFA or health plans. Furthermore, the current appeals process is tailored more to reviewing whether a service should be reimbursed by Medicare or a health plan and less on the important issue of whether a needed service was denied.

In a competitive environment, to attain better risk selection, health plans have the incentive to encourage healthier people to enroll in the plan and to discourage from enrollment those who need more services. This could prompt plans to be less responsive to the grievances of sicker Medicare enrollees.

Subrecommendations

The committee recommends that the existing appeals process be strengthened, streamlined, and better publicized.

Furthermore, the committee recommends that the federal government make available an expedited review and resolution process for Medicare choices (by an agency independent of the health plan and the traditional Medicare program) to review emergency conditions, such as the following: (1) when a situation is life-threatening, (2) when the time involved to review the appeal under the usual process would result in a loss of function or a significant worsening of a condition or would render the treatment ineffective, or (3) when advanced directives or end-of-life preferences are involved.

The federal government should carry out this expedited review through an independent private nonprofit agency in each area of the country. The agency should review any negative findings with the health plan involved and report to the federal government any recommended changes to improve the plan's performance. The cost of this independent, expedited review process should be covered by the Informed Choice Fund. The federal government should be able to assess the costs of these reviews on the health plans when the number of such reviews and negative findings becomes excessive.

HEALTH PLAN, MEDIGAP INSURANCE, AND TRADITIONAL MEDICARE MARKETING PRACTICES

Findings

Past experience with Medigap policy sales has demonstrated the potential for widespread abuse. Federal and state regulatory mechanisms have been put into place to deal with these abuses. However, greater incentives for abuse exist with the sale of alternative health plans. The commission on a single sale can be a significant portion of an agent's compensation.

Health insurance is also complex, and it is difficult for beneficiaries to compare the benefits offered by competing health plans. It will likely remain so for most Medicare consumers. Many Medicare beneficiaries are particularly vulnerable in their need and desire for adequate health care coverage and have been found to have low levels of understanding of Medicare choices.

All of these factors that make elderly beneficiaries especially susceptible to improper marketing practices are underscored by the fact that elderly people have a preference for and rely on one-to-one interactions as a way of learning about their health plan options.

Subrecommendations

To promote comparable levels of accountability, the committee recommends that serious consideration be given to having a new entity approve in advance the public information and marketing materials used by health plans and by the traditional Medicare program. Additionally, the federal government should work with state governments to oversee the marketing of Medigap policies to individuals in the framework of the new requirement for a single open season and conditions of participation.

The committee recommends that the agents and marketers of health plans and Medigap policies be required to inform Medicare beneficiaries up front of their commission for the sale of the policy. Unsolicited door-to-door marketing and outbound telephone marketing should be prohibited. Rigorous marketing rules of conduct should be required to protect beneficiaries. For example,

- lock-in requirements should be made more lenient for beneficiaries who enroll via door-to-door or telephone marketing,

- retroactive disenrollment should be permitted if enrollment takes place as a result of misleading marketing, and
- compensation to marketing agents should be tied to retention of the enrollee in the health plan, and
- retention rates should be reported to potential enrollees by the health plan and by agents.

The committee recommends that the federal government define the basic requirements of any marketing presentation by a health plan or Medigap insurance provider, including such items as providing a copy of a brochure or pamphlet that clearly compared standard health plans, a description of the lock-in provision and a discussion of the availability of the beneficiaries' providers under the plan, and marketing materials in the primary language of the buyer. The federal government should also collaborate with states to ensure consistency in these requirements and should be able to effectively sanction health plans and Medigap insurance providers that break the marketing rules.

RECOMMENDATION 3

The committee recommends that special and major efforts be directed to building the needed consumer-oriented information infrastructure for Medicare beneficiaries. This resource should be developed at the national, state, and local levels, with an emphasis on coordination and partnerships. Information and customer service techniques and protocols developed in the private sector should be used to guide this effort, and the best technologies currently available or projected to be available in the near term should be used.

BENEFICIARY INFORMATION NEEDS FOR INFORMED CHOICE

Findings

Many Medicare beneficiaries do not understand the Medicare choices. Many are fearful of any change in Medicare and distrust the new choices of health plans. A wide range of unbiased information about Medicare choices may increase the level of trust. The committee has found that Medicare beneficiaries want and need standardized, unbiased, clearly understandable information, including the following:

- how the different Medicare choices actually work;
- the out-of-pocket costs of the various plans;
- the experiences of people similar to themselves (e.g., people of the same age, health, sex, ethnicity and cultural background) seeking care under the various Medicare choices;
- how patients have access to and are treated by their doctors (both primary care and specialist physicians) under the various options;
- the accessibility of the services that they are likely to need, especially hospital and ancillary services, as well as the accessibility to cutting-edge care and where it is provided;
- an indication that the information is accurate, timely, reliable, and trustworthy (beneficiaries are savvy in discerning the quality and inherent biases of the information); and
- how participating physicians are paid.

Some groups of beneficiaries, especially those with chronic conditions, desire more specific information, such as protocols for treatment or whether a particular prescription drug is provided in their Medicare choice.

Medicare beneficiaries appear to be active users of media of all types, older adults are particularly oriented toward one-to-one communications with another individual. Furthermore, the committee is pleased with the progress being made by private credentialing organizations like NCQA and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to develop data sets that can be used to certify plans and inform consumers, such as HEDIS.

Subrecommendations

In efforts to communicate the information in the box "Medicare Choices Information for Beneficiaries" to Medicare beneficiaries, a broad range of mass media and other forms of communication should be used. Emphasis should be placed on providing beneficiaries with easy telephone access to individuals who can guide them on the use of the materials providing comparisons of health plans and who can provide additional clarification and information on plans and providers. To the degree possible, health plans will be asked to submit information in a format that will allow beneficiaries or their families to access the information via the Internet.

To establish trust, a private, nonprofit organization should validate and publish summaries of performance data and make more technical backup data available to beneficiaries and others who have a reasonable right to know. Beneficiary surveys should be standardized across plans, they should be audited, they should include a representative sample of those who are covered (including by ethnicity), and they should oversample beneficiaries with chronic or disabling conditions. Materials should be adapted for use by those with special physical limitations, such as poor vision and hearing.

To keep its information as complete and current as possible, this organization should obtain expert advice from national quality and service accreditation organizations in the continuing development of data needs, comparative reports, and surveys for the purposes described above.

MEDICARE CUSTOMER SERVICE AND ENROLLMENT CENTER

Findings

There exists a critical need to increase understanding of and trust in the restructured Medicare program by the public. Medicare beneficiaries and the general public need to be provided with a broad and objective education about the coverages, costs, and purposes of Medicare and the new health plan choices.

Objective and responsive information on all aspects of Medicare choices is also needed to hold the health system and plans accountable. An increase in the amount of this type of information will augment Medicare beneficiaries' trust in the Medicare program and the choice process.

The committee finds that the private sector's information and communication technologies for assembling, cataloging, and making available information on various health plan features to consumers have advanced well beyond those currently being used to serve Medicare beneficiaries. An example cited frequently at the symposium and in the commissioned papers is the notion of customer service centers that allow telephone access to representatives with on-line support. The central availability of the federal government's access to standard data from participating health plans, the traditional Medicare program, and Medigap insurance offers an opportunity to use this technology to better ensure informed choice by beneficiaries and accountability by health plans.

Furthermore, regional and local variations in health plans and health care, coupled with the strong desire among beneficiaries for one-to-one communication, suggest that additional information and service activities be carried out by ombudspersons or agencies at the regional and area levels. Models for such activities exist in information, counseling, and assistance (ICA) programs, which are funded primarily by HCFA.

Subrecommendations

To further these objectives, the committee recommends that the federal government contract with and oversee a private, nonprofit agency to develop a state-of-the-art Medicare Customer Service and Enrollment Center that would (1) administer a Medicare customer services answer center; (2) develop, collect, and distribute open enrollment materials and enrollment data; (3) reconcile enrollment data and payments to plans, including monthly changes and related transactions; (4) provide an evaluation component for the purpose of continual improvement and plan feedback; and (5) contract for regular customer service satisfaction surveys.

The Center would strive to offer Medicare beneficiaries national and regional or local access to the types of services provided by the benefits departments of the nation's large employers, building on the regional-area work of organizations such as ICA programs.

The Center will provide education, counseling, and legal assistance and will process complaints, grievances, and appeals from plan members through regional and local agents such as ICA programs. It will install a tracking system to report all complaints, grievances, and appeals, and will report this information to beneficiaries annually and to health plan chief executive officers monthly.

In carrying out this effort, the Center will take advantage of the most effective and efficient methods of electronic communication, including toll-free telephone communication, on-line communications, town meetings, newsletters, and multimedia techniques, to provide information about plans and the process of choice that is as detailed as possible.

The Center's national, regional, and area activities would be funded by the federal government through the Informed Choice Fund.

CHOICE FACILITATING ORGANIZATIONS

Findings

The committee finds that many independent private organizations that already exist or that might well develop can assist beneficiaries with making informed choices among the options available through the Medicare program. These facilitating or mediating organizations offer services ranging from providing objective additional information on plans and choices beyond what the Center offers, to evaluating plans by additional objective criteria, to prescreening and selecting plans that the organization's customers or members might choose, to bargaining for better value from the plans. In fact, many employers are offering such services to their Medicare-eligible retirees, making Medicare HMOs or Medigap policies, or both, available to them during their annual open seasons.

These Choice Facilitating Organizations do raise some concerns. Insurance brokers or other parties with financial interests may misuse these opportunities to market products rather than provide objective advice. Also, even well-functioning organizations could divert feedback on the services offered by a plan from the Center and its regional agents and dilute the effectiveness of the Center's national reporting. The committee leans toward limiting the establishment of these organizations to groups that do not have a vested financial interest in the choices that consumers make or, at a minimum, requiring such organizations to adequately disclose their sources of funding and potential biases that might result from these financial interests.

Subrecommendations

The committee recommends that nothing in law or regulation should inhibit the development of private organizations whose major purpose is to facilitate choice for Medicare beneficiaries, including groups that offer preselected panels of health plans. Although the committee believes that such organizations should be limited to groups that do not have a vested financial interest in the choices that are made, at a minimum, these organizations should be required to fully disclose their sources of funding and potential biases that might result from these financial arrangements.

To help make the Choice Facilitating Organizations as useful to beneficiaries as possible, the federal government should require health plans and the traditional Medicare program to make available appropriate information to such organizations that have a legitimate interest in that information, such as the data behind quality or accreditation scores.

The committee advocates that public and private entities experiment with such organizations, including providing funding from the Informed Choice Fund to those that meet the criteria of independence and objectivity to augment the work of the Medicare Customer Service and Enrollment Center. Choice Facilitating Organizations may be particularly useful during the early phase of Medicare choice development.

THE INFORMED CHOICE FUND

Findings

The provision of information on Medicare choices to Medicare consumers is in its infancy stage. Most of the information about quality and performance that has been developed and collected has been for large purchasers, plan administrators, or clinicians, not as part of an effort to educate and inform individual consumers.

Subrecommendations

The committee recommends that an Informed Choice Fund be developed for use by the federal government for the purpose of strengthening the infrastructure used to inform Medicare beneficiaries of their health plan choices. The Informed Choice Fund would be used to fund the operations of the Medicare Customer Service and Enrollment Center. Demonstration grants to Choice Facilitating Organizations could be made from this Fund, as desired by the federal government, after the operations of the Medicare Customer Service and Enrollment Center are funded.

The Informed Choice Fund would derive its income from a predictable revenue source, such as a fixed amount from each Medicare beneficiary or a flat amount or a percentage of the monthly Medicare premiums. One demonstration project might be to allow beneficiaries to designate all or a portion of their share of these funds to the Choice Facilitating Organization of their choice.

RECOMMENDATION 4

The federal government should require all Medicare choices to be marketed during the same open season to promote comparability and to enable beneficiaries to adequately assess and compare the benefits and prices of the various options.

COORDINATION OF TRADITIONAL MEDICARE, MEDIGAP INSURANCE AND HEALTH PLANS: MEDICARE CHOICES

Findings

Comparing the prices and benefits of the various Medicare choices is difficult at present because they are not marketed at the same time or under the same ground rules. For example, the beneficiary may not see the high cost (frequently \$1,000 or more) of the traditional Medicare program with Medigap insurance relative to the cost of a managed care plan. In addition, beneficiaries who leave Medicare and their Medigap policy for a managed care plan may find that they cannot repurchase their Medigap policy because of a preexisting condition.

The committee finds that the division of responsibility for enforcing the rules of participation in and compliance with these programs between state and federal government complicates the process of informed choice, grievance and complaint resolution, and plan accountability and fragments the offering of health plans across state lines.

Subrecommendations

It is within this context that the committee recommends that the selection of Medicare choices be coordinated. All three types of plans should be offered during open enrollment periods and under the same conditions of participation.⁵

The federal government should work with state governments to coordinate the federal requirements surrounding Medicare choices with existing state regulations for Medigap insurance and private insurance. The U.S. Congress should consider what policy-making and enforcement activities are most appropriately and effectively conducted by the federal government and which can be delegated to state governments to ensure consistency and economy.

STANDARDIZED PACKAGING, PRICING, AND MARKETING OF BENEFITS

Findings

Through the course of its deliberations, the committee found that although standardized benefits might simplify the choice process for elderly individuals, standardization is likely to dampen innovation and responsiveness to a broader range of consumer desires and preferences. However, the committee also appreciates the advantage for the beneficiary of the current standard benefit categories under Medigap insurance, which facilitate comparisons of the benefits and costs of different benefit options and comparisons of different insurers providing the same option. The committee acknowledges that many employers and private organizations have developed formats that allow the benefits of competing health plans to be clearly displayed and compared. It would be relatively simple for Medicare to do the same.

Terminology relating to the benefits offered by health plans varies greatly and makes it difficult to make clear comparisons among health plans. More research is needed on the types of information that beneficiaries want and need to exercise informed choice and how best to present that information.

Subrecommendations

The committee wants to preserve the general approach taken by the law governing Medigap insurance without restricting choice to the same extent. It believes that health plans should be moved toward standardized packaging, pricing, and marketing of selected benefit packages to allow beneficiaries to more easily compare the benefits offered by different plans. The committee recommends all plans be required to offer and price a basic benefit package (current Medicare Part A and Part B services) and have the option of offering and pricing two other popular benefit packages defined by the federal government and included in basic comparisons promulgated by the federal government. These popular benefit packages should include added benefits shown by market sales and surveys to be of special interest to the elderly (services such as pharmacy, eye care, and foot care) and ones that are popular given

⁵The Physician Payment Review Commission's 1996 Annual Report to Congress provides a worthwhile discussion of the pros and cons of annual versus continuous open enrollment seasons.

the cost. Health plans would be free to offer and price benefit packages other than these two that add to the basic benefit, but these other packages must be clearly identified as nonstandard, must offer substantial differences from the basic benefit package, and would not be included in the Medicare Customer Service and Enrollment Center's standard published comparisons. The federal government should commission the Medicare Customer Service and Enrollment Center to develop and use formats that allow beneficiaries to make easy and clear comparisons of benefits and other information on Medicare choices, drawing on the best practices used by employers and private and public organizations. The federal government should also suggest questions that Medicare beneficiaries should ask about nonstandard packages.

To make this process even easier, the federal government should promulgate common terminology related to benefits. All Medicare choices should use this terminology to describe the benefits of each of their offerings.

The federal government should coordinate its activities with those of state governments to ensure consistency between these benefit packages and those of Medigap insurance.

RECOMMENDATION 5

The committee is concerned about the increasing restrictions on physicians (and the potential conflict of interest of physicians) when they act in their professional role as advocates for their patients and carry out their contractual responsibilities and receive economic incentives as health plan providers. The committee favors the abolition of payment incentives or other practices that may motivate providers to evade their ethical responsibility to provide complete information to their patients about their illness, treatment options, and plan coverages. So-called antiricicism clauses or gag rules should be prohibited as a condition of plan participation.

PHYSICIANS AND PROFESSIONALISM

Findings

The committee recognizes that physicians' advice to beneficiaries is a quintessential part of ensuring informed choice. Because of the inherently personal nature of the physician-patient relationship and its special importance to elderly patients, the committee is concerned about the increasing restrictions on physicians (and the potential conflict of interest of physicians) when they act in their professional role as advocates for their patients and carry out their contractual responsibilities and receive economic incentives as health plan providers. The committee is particularly concerned about reported contractual restrictions (such as antiricicism clauses) on physicians acting in their professional role as a source of advice to their patients. Physicians must maintain their freedom to talk to their patients with full honesty about the clinical aspects of their care and treatment options.

Subrecommendations

The committee recommends that neither the Medicare choices' payment incentives nor their coverage and treatment protocol policies motivate providers to evade their ethical responsibility to provide patients with complete information about their illness and treatment options (such as referrals to a specialist), what to the best of the provider's knowledge the patient's plan covers, and which health plans in the provider's experience provide the broadest range of services to the patient in question.

Competition among Medicare choices is likely to restrict the definitions of inappropriate services by refining the definitions of medical necessity and appropriate services to contain costs and ensure quality. The committee finds that it is important for beneficiaries to have access to the unbiased judgments of their practicing physicians regarding their health needs in the context of plan procedures and protocols so that they, as patients, can make informed choices and thereby shape this new understanding of "appropriate."

Within the scope of its responsibilities, the federal government should identify practices that inhibit open communication between a provider and a patient in any setting and either prohibit them as conditions of participation of plans or require the plan to disclose such practices to potential enrollees. The committee recommends that the federal government require plans to disclose to plan enrollees how physicians get paid, whether they are rewarded for withholding referrals, and any other restrictions affecting how physicians can inform or treat plan enrollees. Similarly, educational materials should make clear the incentives in traditional

Medicare and Medigap insurance to provide unnecessary care and the risks of these incentives.

RECOMMENDATION 6

The federal government should hold Medicare choices accountable by requiring them to meet comparable conditions of participation as a Medicare option and by monitoring and reporting on their compliance with these conditions.

CONDITIONS OF PARTICIPATION FOR MEDICARE CHOICES

Findings

Some private and public employers have administered choice programs for many years and have developed and are continuing to improve the conditions of participation of health plans for ensuring that beneficiaries can make informed choices and for ensuring accountability on the part of the health plans. The very nature of accountability for Medicare health plans suggests that minimum standards should be established for health plans in areas where beneficiaries cannot reasonably be expected to make informed choices or where they might be easily confused or misled. This process of informed choice should be facilitated so that plans compete to exceed those minimum standards.

The committee finds that managed care plans not only pay for the services of providers but that they also use contractual arrangements to establish incentives for and place controls on providers' services. Thus, a beneficiary's choice of health plan can affect not only whether services are covered but also how they are provided. To further the responsiveness of plan management and providers to the special needs and demands of Medicare beneficiaries, the committee suggests that plans actively and meaningfully include beneficiaries in their governance and board activities and otherwise integrate the consumer voice into the plan's management and decision-making structure.

This said, the committee acknowledges that performance and disclosure requirements cannot compensate for limits on monetary resources for coverage. No amount or type of oversight and regulation can offset the intrinsic limitations on quality and access that necessarily follow from low levels of funding by the political process or the inability or unwillingness of beneficiaries to pay additional fees for health services.

Subrecommendations

The committee recommends that the federal government be given the flexibility to adjust the conditions of participation to take into account the evolution of higher standards and new systems and structures for ensuring informed choice and public accountability of Medicare choices.

QUALITY ASSURANCE AND OUTCOMES

Findings

The availability of Medicare choices introduces a potential for competition among plans on the basis of improvements in quality of care. To capitalize on this potential, the quality of service provided by health plans must be measurable and must be communicated to beneficiaries in a way that is relevant to them so that quality can be taken into account and so that a beneficiary can make an informed choice. Choice in health care, as in any environment, also introduces incentives to restrict the provision of or payment for services to remain competitive. This can produce effective and needed economies by reducing inappropriate or noncovered services. It may also, however, reduce the amount of appropriate care provided. Quality measures, monitoring, and meaningful ways of disclosing and communicating findings are needed so that the federal government and beneficiaries can hold plans accountable for reaching an appropriate balance between restricting inappropriate care and providing appropriate care.

The committee finds that quality measurement and communication are still in the early stages of development, especially quality measurements based on outcomes. Important initial efforts are under way by private credentialing agencies, such as NCQA's HEDIS, JCAHO, the Foundation for Accountability, and others, to develop reporting systems and measures of health plan quality. These efforts, however, reduce but do not eliminate the risk of poor quality.

Subrecommendations

To best ensure quality, all Medicare choices should be subjected to comparable state-of-the-art standards and monitoring for quality. The federal government should use the best of the currently available technology to set standards and monitor the quality of health plans. When the standards and processes of private credentialing agencies meet or exceed those of the federal government, private organizations should be used to reduce duplication in the market. The federal government might well foster competition and innovation among private credentialing agencies for different aspects of this function.

Communication with beneficiaries about the quality of a health plan and traditional Medicare plans should be done by the Medicare Customer Service and Enrollment Center by using the latest information available from credentialing processes and the latest techniques for communicating plan performance. In this vein the federal government should give priority to research and demonstrations on communicating quality performance information to beneficiaries.

The committee recommends the development of common definitions for reporting quality for use by individual plans and for auditing plans against their own published reports to the federal government.

MANAGED CARE AND UNDERSERVED POPULATIONS

Findings

The committee is concerned about ensuring access to health plans and their services for all beneficiaries, including those in vulnerable populations and underserved areas. Although the average Medicare beneficiary has been shown to have good access to care, certain groups who have been identified as vulnerable in traditional Medicare may be at risk for access problems in Medicare managed care. These groups have been identified by PPRC to include African-American beneficiaries and those who live in Health Professional Shortage Areas or urban and rural poverty areas. Evidence indicates that managed care arrangements have been slow to include underserved populations, especially those in rural areas (Institute of Medicine, 1996).

At the workshop and through the commissioned papers the committee was made aware of the special value that elderly individuals place on having easy access to their physicians, and the importance that they place on being treated by their providers in a respectful and a socially and culturally sensitive way. The committee heard again and again that elderly individuals place key importance on their ability to have access to "their" traditional providers with whom they have developed a personal relationship.

The importance of considering the effect of personal and cultural factors on access is heightened by the changing demographics of the U.S. population. The committee heard that certain Medicare beneficiaries (particularly low-income and minority groups) may be at significantly higher risk of not being able to continue to be seen by their traditional network of providers in an environment of managed care. Because of the lower socioeconomic status of many individuals who are members of minority groups, a managed care plan may be the only delivery option that is affordable.

As managed care plans continue to develop they will have an increased responsibility to improve access for underserved populations. The committee believes that health plans should be held responsible for serving their entire service area without compromising access or quality of care. The committee found that some providers who have served their communities for many years or who are part of essential community provider networks, have not obtained the credentials required by some managed care organizations either because of institutional racism or common practice within their specialty to forego board certification. It is important that health plans develop several measures of clinical competence that are sensitive, valid, and reliable in their ability to assess clinical competence through both outcome and process indicators. The committee heard testimony that managed care plans often do not disclose their credentialing standards and policies. At the very least, such disclosure should be required. The committee lauds the efforts under way in HCFA, PPRC, a number of health foundations and other groups to track and address key issues that could arise in monitoring access to care under a restructured Medicare program.

Subrecommendations

Broad access for Medicare beneficiaries is key. The committee recommends that the federal government ensure that there is adequate access and choice of plans for individuals in all socioeconomic, cultural, and language groups and for underserved

areas and populations. Elderly beneficiaries particularly value care that is respectful, personalized, and culturally sensitive. When warranted and documented (i.e., when access is demonstrably inadequate), the federal government should require the plans in an area to improve their contracting with community-based providers who meet quality-of-care standards as a condition of participation.

RECOMMENDATION 7

Serious consideration should be given and a study should be commissioned for establishing a new function along the lines of a Medicare Market Board, Commission, or Council to administer the Medicare choices process and hold all Medicare choices accountable. The proposed entity would include an advisory committee composed of key stakeholders, including purchasers, providers, and consumers.

MEDICARE MARKET BOARD AND HCFA

Findings

Bearing in mind the recommendations that the committee has made regarding ensuring public accountability and informed purchasing for beneficiaries in an environment of choice, the committee had a number of concerns as it relates to the choice management capabilities of HCFA, as it is currently structured, to effectively manage Medicare choices. The committee spent considerable time discussing the challenges and complexities of effectively managing two very different and potentially competing programs. For example:

- The administration of the multiple choice program and the management of the traditional Medicare programs involve very different missions and orientations.
- The two functions require different types of management, staff expertise, backgrounds, and knowledge. The committee is concerned that staff and senior managers with extensive experience in managing various aspects of multiple choice in the private sector be recruited and employed for this effort.
- The functions call for different organizational and corporate cultures, one operating a stable traditional public indemnity insurance program and the other a purchaser- and customer-oriented program that is required to be responsive to a diverse group of private programs in a rapidly changing and dynamic marketplace.
- A faster response to changing market conditions and opportunities is required for the effective management of competing plans to provide the best options for beneficiaries. Such responsiveness may be hard to achieve with the regulatory constraints of HCFA.
- The committee believes that these strengthened and new responsibilities for managing the choice of plans must be supported by adequate organizational, financial, and staffing resources, which are needed to effectively and efficiently accomplish the mission described here.

Subrecommendations

The committee believes that these growing choice management functions would benefit from an organizational identity with the stature to facilitate recruitment of the needed leadership and staff and to build public trust. For that reason the committee recommends that serious consideration be given to establishing a new function along the lines of a Medicare Market Board, Commission, or Council that would include an advisory committee with key stakeholders (i.e., purchasers, providers, and consumers).

The committee was not able to research adequately the question of where this function should be located in government. The committee is aware of current initiatives to simplify and streamline government regulations as well as the efforts being made by HCFA to address some of the committee's concerns. The committee's discussions included the option of incorporating the new Medicare Market Board entity within HCFA, but with dedicated management and resources; establishing a Federal Reserve Board type of agency that has greater flexibility in rule making; establishing a PPRC- or ProPAC-type entity reporting to the Congress; as well as other possibilities.

With that in mind and given the potential impact of the proposed new entity on the health care economy and the well-being of 37 million beneficiaries, the committee recommends that the U.S. Congress commission a study on what functions should be included in any new entity and what functions should stay with the present organizational structure, the roles and experience of federal agencies with a comparable mix of functions, the rationale for their structure, their organizational placement (including their relationship to the U.S. Congress and the executive

branch) to better assess the advantages and potential shortcomings of moving in this direction.

In recommending the consideration of a new function such as a Medicare Market Board, the committee was cognizant of the fact that even a new entity will be limited or circumscribed by the realities of the political and fiscal environments in which it must operate and be accountable.

The committee envisions any proposed entity to have general responsibilities in the following areas:

- Data collection, data publication, consumer education, and support

Contract with a Customer Service and Enrollment Center for these functions and augment the Center's services by using Choice Facilitating Organizations.

- Health plan standards

Consult experts and conduct research and demonstrations to refine the conditions of participation by health plans on an ongoing basis to reflect the service and quality that the government expects for Medicare beneficiaries, regardless of the plan that they choose. The conditions would be set on a national basis and would be measurable and subject to an annual evaluation of compliance. To the greatest extent possible they would be consistent with standards used by the private sector to minimize duplication.

Invoke specific sanctions in the event that the standards of a plan fall below the set standards.

- Benefits, quality, and fair payment to health plans

Continually review clinical developments and services pertaining to what constitutes quality or appropriate care and refine the definitions of benefits under Medicare Part A and Part B.

Review developments in the health insurance marketplace and refine the standard benefit description, pricing, and marketing requirements.

Review risk selection in the traditional Medicare program and health plans and develop procedures or recommendations to the U.S. Congress for controlling or adjusting for adverse and favorable selection.

- Evaluation and improvement of multiple choice in Medicare

Review the workings of the multiple choice market for Medicare beneficiaries and report to the U.S. Congress on the extent to which beneficiaries are able to make informed choices, the extent to which government and beneficiaries are succeeding in holding plans accountable for ensuring quality of care and containing costs, and ways to improve the system's performance.

Review traditional Medicare and health plan costs and performance to determine whether the amount and form of the federal government's contribution to costs (e.g., premium payment) yields the government and its beneficiaries both containment of costs and assurance of quality.

Report and recommend changes to the U.S. Congress to better hold plans accountable to these ends.

In conducting each of its responsibilities, it would adhere to rigorous conflict-of-interest standards.

BOX 3-1
Medicare Choices: Information for Beneficiaries

To provide the necessary information for informed purchasing, the committee recommends that the federal government make available to beneficiaries, directly or through health plans, the following types of information on Medicare choices:

1. The enrollment and disenrollment rules, the choice process, and the range of services available from the health plans.
2. How traditional Medicare and Medigap insurance, in comparison with alternative health plans, pay and contract with providers, for example, choice of providers and portability.
3. Comparative benefits, including
 - emergency and out-of-plan urgent care;
 - hospital services (including access to centers of excellence);
 - nursing home, home health, and hospice services;
 - prescription benefits;
 - physician services, including the availability of specialists, physical care, dental care, and mental health care, and foot care, dental care, and mental health care, and
 - services of alternative providers such as chiropractors.
4. Comparative costs, including premiums, cost-sharing, and balance billing, with examples of comparative costs for different classes of beneficiaries, for example, the well elderly; disabled, institutionalized, and chronically ill people; and individuals with major illness episodes while on Medicare. Medigap insurance premiums should be shown to be in addition to the Part B premium.
5. Comparative performance on clinical, structural, and satisfaction benchmarks.
 - scientifically valid process and outcome measures in a form salient and relevant to beneficiaries, including the
 - percentage of beneficiaries with diabetes who receive an annual eye examination.
 - percentage of female Medicare beneficiaries who receive an annual or biannual mammogram and Pap smear,
 - percentage of males who receive a prostate examination,
 - percentage of beneficiaries who receive preventive services, such as hypertension screening and influenza and pneumococcal vaccinations, and
 - recidivism rate for various diagnoses;

- access measures, including
 - the percentage of referrals denied or unavailable,
 - the average waiting time to obtain a referral,
 - average times to obtain an appointment once a referral has been made,
 - ease of phone access and average waiting times in a physician's office, and
 - physician turnover rates; and
 - satisfaction measures (specifying those with chronic conditions or disabilities), including
 - disenrollment information, including the percentage of persons who disenroll within 3 months of enrollment,
 - appeals and grievance information, including the numbers, reasons, and resolutions of grievances and appeals per Medicare choices organization,
 - access and quality findings from HCFA monitoring surveys and relevant state regulatory reports, and
 - findings from surveys commissioned by the organization on satisfaction with physicians and hospital care, access to specialists, and other factors found to be important to beneficiaries.
- 6. A clear description of the details of each plan and the Medigap policy, including
 - in- and out-of-network access and costs;
 - how referrals are made (e.g., who makes the referral decisions and on what basis);
 - appeals and grievance systems;
 - up-to-date listings of all providers by type and specialty, credentials, and whether an individual provider is accepting new patients from the plan;
 - financial and contractual arrangements between plans and providers that may influence their decisions regarding services in the judgment of the federal government;
 - financial and solvency status; and
 - use of out-of-area specialty centers.

On request, policies or protocols for covering or providing specific services (such as a prescription drug) or services for specific conditions (such as chronic obstructive pulmonary disease, congestive heart failure, diabetes, and joint replacement) should be provided.

BOX 3-2
Conditions of Participation

The committee recommends that all *Medicare choices* meet the following minimum standards:

- participate in the annual open season and sell policies to Medicare beneficiaries during that open season or on certain other occasions, such as when a beneficiary first becomes eligible;
- offer open enrollment, guaranteed renewal, and no clauses precluding enrollment because of a preexisting condition for newly eligible beneficiaries and for beneficiaries changing plans;
- offer Part A and B benefits (except for Medigap policies) and meet other Medicare benefits requirements:
 - provide information specified by the federal government to ensure informed choice by beneficiaries;
 - meet quality certification requirements comparable to those already in use and in development by recognized national private accrediting entities and require appropriate progress and improvement against such standards over time;
 - have resources, including appropriate mixes of specialists and referral resources, to provide benefits throughout service areas to a reasonable degree defined by the federal government so as not to divide metropolitan areas or counties except when natural barriers or other conditions divide service areas;
 - provide a user-friendly, well-communicated, and responsive appeals and grievance process and allow retroactive disenrollment of beneficiaries who are determined by a fair and appropriate process to have misunderstood the implications of their choice and who have suffered serious financial or other consequences;
 - meet fair marketing standards;
 - meet specified fiscal solvency and financial disclosure requirements, allow compliance audits of financial and quality assurance operations, agree to use federal government-promulgated terms for describing coverages, and agree to accept enrollees without prejudice in all circumstances and particularly when the beneficiary has been enrolled in a plan that has gone out of business or become insolvent within the prior 60 days;
 - not discourage providers from advising patients regarding their treatment options and plan coverages;
 - provide such data to the federal government as required for it to test the plan's performance and compliance; and
 - provide such information as it may require to the Medicare Customer Service and Enrollment Center.

Chairman THOMAS. Thank you very much.
Ms. O'Kane.

STATEMENT OF MARGARET E. O'KANE, PRESIDENT, NATIONAL COMMITTEE FOR QUALITY ASSURANCE

Ms. O'KANE. Good afternoon, Mr. Chairman. My name is Margaret O'Kane, and I am the president of NCQA, the National Committee for Quality Assurance. I want to thank you for the opportunity to testify.

By way of background, NCQA is an independent, nonprofit, 501(c)(3) organization governed by a board of directors which includes employers, consumer representatives, health plans, quality experts, and a representative from organized medicine. Our labor seat was just vacated about 1 month ago.

NCQA oversees two complimentary approaches for the evaluation of managed health care plans. The first is accreditation, and by the end of this year we will have surveyed over one-half of the Nation's HMOs. We started this program in 1991. The second approach is performance measurement using NCQA's Health Plan Employer Data and Information Set, HEDIS. In 1995 nearly 90 percent of all HMOs reported HEDIS performance data. As you heard from Dr. Vladeck's testimony, HCFA is mandating the collection of HEDIS data for Medicare risk contractors.

Our mission is to provide the marketplace with reliable information on quality, so that purchasers and consumers can base their decisions on both cost and quality. Nearly 25,000 visitors a month now access our home page on the World Wide Web. They come to check and see if a particular plan is accredited, or to learn more about HEDIS. For those consumers who don't use the Internet, we have a 1-800 number which they can phone to receive a free copy of our accreditation status list. We get, I think, about 1,500 requests a month for that, mostly from consumers.

Our accreditation program sends out a team of physicians and quality experts to evaluate a health plan against standards in six different areas. It's not an easy program, and 11 percent of the plans fail outright. Our survey teams go onsite to the health plan and check for compliance with each of the standards.

For example, we require the health plan to demonstrate whether it has improved the quality of care and service its members receive. We also want to know if the health plan has imposed gag rules on its physicians, which they, of course, are not allowed to do, or what happens when a consumer goes to the emergency room for what he or she genuinely believes is an emergency. We check on the extent of the due diligence the health plan performs on its physicians and hospitals. Our surveyors look to see if the health plan supports physicians' efforts to deliver preventive care, and if the health plan is denying payment for service, we want to see that those decisions are made only by physicians and based on sound medical evidence.

Finally, our surveys conclude with a review of medical records, where our physicians evaluate the quality of care in the records and the quality of the recordkeeping.

Our second approach—and I want to stress that it's complementary to accreditation—to evaluating managed care is performance measurement using HEDIS. HEDIS is a standardized set of performance measures designed to provide purchasers and consumers with the information needed to reliably compare the performance of managed care plans.

In combination with our accreditation program, HEDIS provides the most complete view of health plan quality available to guide choice among competing health plans based upon demonstrated value rather than simply on cost. It is sponsor supported and maintained by NCQA as part of our commitment to evaluating and publicly reporting on the quality of managed care plans.

HEDIS 3.0, which is our newest version, and was just recently published, addresses the range of health care issues, from prevention and early detection to acute and chronic care for all age groups, and for conditions of high prevalence, such as heart disease, diabetes, smoking addiction, breast cancer, and AIDS. It was developed by a broad-based committee and included major purchasers, Medicare and Medicaid officials, health plans, and many quality experts. It was an open process and included a public call for measures in which we asked the greater community in the country to submit their suggestions.

When I first testified before this Subcommittee nearly 3 years ago, there was little activity to report with regard to public/private coordination at the Federal level. NCQA really began by serving the needs of large corporate purchasers.

I am pleased to report today, though, that the situation has changed dramatically. HCFA was an active participant in the development of HEDIS 3.0 and has recently mandated HEDIS reporting for Medicare HMOs. We will be working with HCFA in the coming months and years to assist with their collection, auditing, analysis, and reporting of HEDIS data.

We are also engaged in discussions with HCFA on how their certification and survey process for Medicare health plans could benefit from increased coordination with NCQA accreditation.

Although we're very pleased with what we have accomplished over the past 3 years, much work remains to be done. Many health plans have not yet applied for accreditation, and many more are struggling to gather the necessary data for the measures in HEDIS.

Mr. Thomas, your comment about information systems is really at the heart of this issue. Many health plans are having to go into paper medical records to gather information, and the records are widely dispersed in the medical community.

Solutions will involve both the public and private sectors, and NCQA is fortunate to have the support of both groups.

I want to thank you for the opportunity to testify.
[The prepared statement follows:]

Statement of Margaret E. O'Kane, President, National Committee for Quality Assurance

NCQA OVERVIEW AND BACKGROUND

Good afternoon, my name is Margaret E. O'Kane, and I am the President of the National Committee for Quality (NCQA).

By way of background, the National Committee for Quality Assurance (NCQA) is an independent not-for-profit 501(c)(3) organization governed by a Board of Directors which includes employers, consumer and labor representatives, health plans, quality experts, and representatives from organized medicine. NCQA oversees two complimentary approaches for the evaluation of managed health care plans: accreditation and performance measurement using NCQA's Health Plan Employer Data and Information Set (HEDIS). In 1995, nearly ninety percent of all HMOs reported HEDIS performance data, and by the end of this year NCQA will have accredited well over half the nation's HMOs.

NCQA's mission is to provide information that enables purchasers and consumers of managed health care to distinguish among plans based on quality. Nearly 25,000 visitors a month now access our homepage on the World Wide Web (www.ncqa.org) to search the Accreditation Status List, download an Accreditation Summary Report, or learn more about the Health Plan Employer Data and Information Set (HEDIS) version 3.0.

Whether its working with the Health Care Financing Administration (HCFA) and the Agency for Health Care Policy and Research (AHCPR) on the next generation of health plan performance measures, or with the Office of Personnel Management (OPM) to assist FEHBP enrollees with their choice of health plans, NCQA enjoys a productive and positive relationship with many branches of the federal government.

We do not, however, see ourselves as a replacement for government oversight of health plans. Instead, we view our work as complementing the function of government by empowering purchasers, both private and public, individual and commercial, with information to guide choice based on both cost and quality. Absent reliable information on health plan quality, purchasers and consumers will buy on price alone.

Although not viewed as a replacement for government oversight, state and federal agencies can take advantage of our work and better utilize limited government resources. For example, nine states have incorporated the results of our accreditation reviews rather than "re-inventing the wheel" and subjecting health plans to a duplicative review process. An additional six states require NCQA accreditation for those health plans seeking to enroll state employees. The result is a more focused state oversight system that reduces state expenditures and health plan administrative expenses.

When I first testified before this Subcommittee nearly three years ago, there was little activity to report with regards to public/private coordination at the federal level. I am pleased to report a much changed situation today. HCFA was an active participant in the development of HEDIS 3.0 and has recently mandated HEDIS 3.0 reporting for Medicare HMOs. We are also engaged in discussions with HCFA on how their certification and survey process for Medicare and Medicaid health plans might benefit from increased coordination with NCQA accreditation. During last Fall's open season, the Office of Personnel Management reported the NCQA accreditation status for health plans contracting with the Federal Employees Health Benefit Program, and the Department of Defense is examining how NCQA accreditation and HEDIS can be best used to evaluate the TriCare program. In short, I am pleased to report that the federal government has made great strides in working with this organization over the last three years.

ACCREDITATION

NCQA accreditation evaluates how well a health plan manages all parts of its delivery system—both providers (e.g., physicians, hospitals, carve outs) and administrative services—in order to continuously improve health care for its members. Perhaps the highest praise for the rigor of our standards and process comes from the growing number of both employers and labor unions who are requiring or requesting accreditation of the plans they do business with.

Our accreditation standards are the most widely applied managed care standards in the nation and represent excellent business practice in six different areas:

- Quality Improvement: Does the plan fully examine the quality of care given to its members? How well does the plan coordinate all parts of its delivery system? What steps does it take to make sure members have access to care in a reasonable amount of time? What improvements in care and service can the plan demonstrate?

- Physician Credentials: Does the plan meet specific NCQA requirements for investigating the training and experience of all physicians in its network? Does the plan look for any history of malpractice or fraud? Does the plan keep track of all physicians' performance and use that information for their periodic evaluations?

- Members' Rights and Responsibilities: How clearly does the plan inform members about how to access health services, how to choose a physician or change physicians, and how to make a complaint? Does the plan place any restrictions on the clinical dialogue between practitioner and patient? How responsive is the plan to members' satisfaction ratings and complaints?

- Preventive Health Services: Does the plan encourage members to have preventive tests and immunizations? Does the plan support physician efforts to deliver preventive services? Is there evidence of monitoring of the success of preventive care? Is there evidence of improvement, where monitoring suggests an opportunity?

- Utilization Management: Does the plan use sound clinical evidence and consistent processes when deciding what health services are appropriate for individuals' needs? When the plan denies payment for services, does it respond to member and physician appeals in a timely fashion? Does the plan protect against underutilization? Are decisions made by individuals with sufficient expertise to make them? Are the criteria for appropriateness of medical services available to participating physicians?

- Medical Records: How consistently do the medical records kept by the plan's physicians meet NCQA standards for quality care? For instance, do the records show that physicians follow up on patients' abnormal test findings?

During an NCQA review a health plan's performance against each of the standards is assessed both on-site and off-site by a team of physicians and managed care experts. A national oversight committee of physicians analyzes the team's findings and assigns an accreditation level based on the plan's performance compared to NCQA standards.

Accreditation Status List, Summary Statistics, January 30, 1997

| Decision | Number | Percent |
|---------------------------------|--------|---------|
| Full | 118 | 47 |
| One-Year | 85 | 34 |
| Provisional | 24 | 9 |
| Denial | 25 | 10 |
| Under Review | 1 | <1% |
| Total | 253 | 100 |
| Decisions Pending | 18 | |
| Initial Reviews Scheduled | 59 | |
| Grand Total | 330 | |

NCQA receives approximately 5,000 phone requests per month for the free Accreditation Status List, which lists plans by state or alphabetically by name. Our HomePage on the World Wide Web (www.ncqa.org) receives an additional 25,000 visitors a month, and allows consumers to search by health plan name or state to determine accreditation status. Accreditation Summary Reports, which provide more detailed information on individual health plan accreditation decisions, are available for every review and re-review conducted since July 1995. These Accreditation Summary Reports illustrate how an individual plan scored against a plan average in each category of standards, and illustrate both strengths and weaknesses.

MANAGED BEHAVIORAL HEALTH CARE ORGANIZATIONS

During the 1980s, employers, unions, and consumer groups became increasingly concerned about the escalating cost of behavioral health services. In the mid-1980s, managed behavioral healthcare organizations emerged in an attempt to better meet the demand for behavioral health care service. Since that time, the managed behavioral health industry has grown rapidly; it currently provides behavioral health care to more than 120 million people.

There are more than 300 MBHOs in operation today, ranging widely in size. These plans have focused most of their efforts on meeting the needs of the commercial market. However, as public purchasers are increasingly seeking managed care contracts, the size of the potential market for managed behavioral health has grown considerably. A number of states cover behavioral health services for Medicaid beneficiaries through managed care plans. Moreover, Medicare legislation in 1997 may increase the number of Medicare beneficiaries receiving services through MBHOs.

NCQA convened a Behavioral Health Task Force to assist in developing standards that would reflect consensus on desired managed behavioral health care industry performance. This Task Force included experts in mental health and substance abuse, employers and purchasers, consumer and government representatives, and

MCO and MBHO medical administrators. The work of the task force was informed by several large employers who had developed MBHO quality assessment tools on their own. Lessons from smaller, plan-specific quality initiatives were also integrated into the standards.

The Behavioral Health Standards are organized into seven categories: Quality Management and Improvement; Accessibility, Availability, Referral, and Triage; Utilization Management; Credentialing and Recredentialing; Members' Rights and Responsibilities; Preventive Behavioral Health Care Services; and Clinical Evaluation and Treatment Records. NCQA released the standards for public comment earlier this year, and has completed three pilot reviews to test the standards, assessing the quality of behavioral health services in two MBHOS and one MCO. It is our hope that these standards will encourage improvement in the overall quality of the managed behavioral industry. By encouraging the adoption of a "best practices" approach to continuous improvement, the standards may strengthen clinical decision making and foster the development of more effective quality improvement systems. Likewise, future behavioral health measures included in the Health Plan Employer Data and Information Set (HEDIS) are more likely to emerge in an environment supportive of population-based quality management. Finally, widespread implementation of these standards may offer an opportunity for strengthening the partnership between behavioral health delivery and medical care delivery to achieve a higher quality of care for the consumer.

HEALTH PLAN EMPLOYER DATA AND INFORMATION SET VERSION 3.0 (HEDIS 3.0)

OVERVIEW AND HISTORY

HEDIS 3.0 represents a giant leap forward in the nation's effort to compare the performance of health plans in areas of critical importance to purchasers and consumers, and takes the national standard in performance measurement to an even higher level. In an era of substantial discord, a committee representing diverse and, often, competing interests achieved consensus about what needs to be and what can be measured in managed care at this time. The product of these debates about plan performance accountability and measurement science—HEDIS 3.0—is a set of performance measures of unprecedented scope and reach.

This latest version of HEDIS also sets up a process for its own continuing enhancement that involves the periodic, open and rigorous solicitation and selection of new measures. This will give the public ever more comprehensive and meaningful information on plan performance as we move toward the 21st century.

MEETING THE NEEDS OF PURCHASERS AND CONSUMERS

HEDIS is a set of standardized performance measures designed to assure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. It is sponsored, supported and maintained by the NCQA, as part of our commitment to evaluating and publicly reporting on the quality of managed care plans. HEDIS—in combination with information from NCQA's accreditation program—provides the most complete view of health plan quality available to guide choice among competing health plans based upon demonstrated value rather than simply on cost.

PURCHASER SUPPORT

As I mentioned earlier, the US Health Care Financing Administration (HCFA), which contributed financial support to the development of HEDIS 3.0, has announced that managed care plans serving Medicare beneficiaries will be required to submit data on those HEDIS measures relevant to Medicare, beginning in 1997. In addition to HCFA, the Managed Health Care Association (MHCA)—an organization of over 80 Fortune 500 companies—has called on all employers to adopt the measurement system.

CHANGES TO HEDIS 3.0

For the first time, health plans will be expected to measure how well their patients are able to function in their daily lives, in a way that will open a window on health plan success at improving functional health. For the first time, satisfaction results will be assessed with a single instrument, providing the ability to capture and compare members' experiences across different health plans. Not only is it important, for example, for a health plan to measure results in cases of coronary artery bypass graft surgery, but it is equally important that health plans dem-

onstrate that they do what they can to keep members from using tobacco and, therefore, getting heart disease in the first place.

HEDIS 3.0 addresses the range of health care issues from prevention and early detection to acute and chronic care; for populations of children, adolescents, adults and seniors; and for conditions of high prevalence such as AIDS, breast cancer, smoking addiction, heart disease and diabetes.

HEDIS 3.0 brings private sector and public sector measurement efforts together. For the first time, the same measurement standards will be applied to care, whether provided to commercial enrollees, or to Medicare risk or Medicaid beneficiaries. Bringing the private and public sector together in this way not only increases the efficiency of measurement, but creates the possibility of comparing care across populations as well as across health plans.

HEDIS 3.0 addresses the range of issues that are important to purchasers and consumers when choosing a health plan, including clinical results, access to needed services, satisfaction with the experience of care, the cost of care and other key dimensions. Includes a process for its ongoing improvement. HEDIS 3.0 is a unique structure—including not only the national standards for performance reporting, but additional measures which are in development and are included as a “testing” set of measures. Inclusion of these measures is a signal to managed care plans of what they may need to measure in the future, and creates the opportunity for NCQA to work with researchers, consumers, purchasers and health plans to refine these measures prior to their widespread implementation.

DIFFERENCES WITH OTHER MEASUREMENT EFFORTS

While HEDIS is the national standard in performance measurement for health plans, there are other measurement efforts underway in health care. HEDIS differs from those efforts in a number of ways. HEDIS measures have a track record and are widely reported. Purchasers and consumers want to be confident that health plan measurements are statistically valid and reflect real differences in health care. HEDIS measures are precisely defined, validated, and have been successfully used by more than 87% of managed care organizations to date. There is ample evidence that these measures have permitted consumers and purchasers to distinguish between plans, and that they can be used to successfully track improvement or decline in the performance of health plans over time. Furthermore, surveys suggest that close to sixty percent of large employers are already using HEDIS to assess plans. HEDIS measures are specifically designed to help purchasers and consumers make comparisons. While there are many valid reasons for measurement (e.g., supporting internal improvement, tracking performance over time), not all measures have the statistical properties needed to detect differences between health plans in order to guide choice—and no other set of measures is designed specifically with that purpose in mind. In addition, not all measures are designed to be relevant to purchasers and consumers, but this is an explicit objective of HEDIS 3.0.

HEDIS 3.0 DEVELOPMENT PROCESS

HEDIS 3.0 was developed by a broad-based committee—the Committee on Performance Measurement—whose members were chosen to reflect the diversity of constituencies that performance measurement must serve: purchasers, both private and public—Medicare and Medicaid; consumers; organized labor; medical providers; public health officials; and health plans. In addition, a number of other individuals were asked to serve on the CPM, to bring other important perspectives, as well as additional expertise in the areas of quality management and the science of measurement. The CPM and its related subcommittees were organized and staffed by NCQA; funding for the work came from a wide variety of public and private sources.

EXPERTS AND INFRASTRUCTURE SUPPORTING THE CPM

Throughout the course of its work, the CPM was fortunate to be able to draw upon a broad base of expertise and knowledge. To help its members understand what information was important to purchasers and consumers, the CPM commissioned an expert subcommittee to prepare a report on the information needs of Medicare; it reviewed the work of NCQA's Medicaid Workgroup which—with funding from the David and Lucile Packard Foundation—had produced Medicaid HEDIS; it commissioned a synthesis of available knowledge about how privately insured consumers make choices about health plans, and brought a number of experts in that field to its meetings; and—with support from the Commonwealth Fund—it commissioned focus groups to get consumer reaction to possible HEDIS 3.0 measures. To help CPM members understand the science and state-of-the-art in performance

measurement, the Committee organized a Technical Advisory Committee (the TAC), and commissioned papers by leading experts which laid out pressing and fundamental issues in the field. These papers, and the TAC, brought the necessary level of scientific rigor to the CPM's deliberations.

CHARGE TO THE CPM

When the CPM was launched in September 1995, it was charged with moving HEDIS 2.5 to the next level. The group defined its development platform as the existing HEDIS measurement sets that were already in widespread use—those developed for commercial enrollees (HEDIS 2.5), and those developed for the Medicaid program (Medicaid HEDIS). The CPM's strategy was to integrate these measures into a single, non-duplicative, set, and then to expand those measures (where feasible and appropriate) to include the Medicare risk population. This platform represents an historic first—the integration of public and private reporting requirements in health care.

Next, the CPM mapped out a strategy to develop additional measures—not only for HEDIS 3.0, but for future generations of HEDIS—in order to continue evolving the set to ever more relevant and comprehensive levels. The CPM decided that it could best accomplish this by tapping the collective knowledge and expertise of clinical and measurement experts across the country. As a result, it laid out an open process for developing measures: one that began with the CPM requesting, through a Public Call, proposals and suggestions for new measures. At the same time, the CPM developed criteria to systematically and objectively guide the evaluation and selection of measures that were submitted.

PUBLIC CALL FOR MEASURES

As part of this Public Call for Measures, the CPM described the basic aspects of health plan performance that are important to purchasers and consumers. These defined the eight performance domains for which measures were sought:

- Effectiveness of care: The Committee's objective here was to develop measures that assess how well the care delivered by a managed care plan is achieving the clinical results that it should. Interest in this domain reflects a desire to establish that the health plan is responding to the needs of those who are ill ("does the health plan make me better when I am sick?"), and also to the needs of the well ("does the health plan keep me well, when I am healthy?"). It also reflects a desire to establish that the plan can provide excellent results, not only for the sort of care that "I know I will need," or even that "I expect I will need," but also for the sort of care that "I hope I won't need (but will need desperately if I do)."
- Accessibility and availability of care: The Committee's objective here was to develop measures that permit us to assess whether care is available to members, when they need it, in a timely and convenient manner. The desire for information about the accessibility of health care is an expression of a belief that accessibility is a precondition of effective care; but also of a belief that the managed care plan has responsibility for managing care so that it is available to those who need it.
- Satisfaction with the experience of care: These measures are intended to provide information about whether a health plan is able to satisfy the diverse needs of its members. The desire for information in this area recognizes that members tell us important things about the care they receive. It reflects the opinion that encounters with the health plan should occur in a manner that is responsive to and respectful of the preferences and interests of its members, and that its members' satisfaction is the most revealing summary of the extent to which this is so.
- Cost of care: The Committee was seeking measures that would permit the comparison of health plans based on the "value" of the services they deliver. To some extent, we can do so by evaluating the results they achieve (above) against the premium collected. However, the cost of care for members is not only the premium they pay, but the additional and rising costs they face (out of pocket) for services that are not covered, or for services that involve copayment and/or deductibles.
- Stability of the health plan: Health plan stability is important, because consumers make enrollment decisions that generally bind them for a year. Should the plan's network of providers change significantly—or should the plan become insolvent—the member's health care could be badly disrupted. The CPM hoped to provide some measures to help consumers estimate how likely these problems might be.
- Informed health care choices: The Committee believes that an important objective of a good managed care plan should be to help members become active partners in their health care decisions. To do so means that the health plan must equip members to make informed choices about their care. The Committee's objective in defin-

ing this domain was to develop measures that would assess how effectively health plans accomplished that result.

- Use of services: How a health plan uses its resources is a signal of how efficiently care is managed and whether or not needed services are being delivered; it may also provide some information about where there are opportunities to improve both the effectiveness and efficiency of care. The Committee recognized that these may be particularly important to purchasers who want to know how their health care dollars are being spent and want to ascertain if their employees are getting what they need. The Committee's objective in laying out this domain was to develop measures that would permit users to understand patterns of service use across different health plans.

- Plan descriptive information: Finally, there is clear interest in some of the attributes and operating characteristics of the health plan itself; in particular, in a variety of elements of plan management (including a description of selected network, clinical, utilization and risk management activities). While these are not "performance measures" per se, they are "bits" of information that consistently have been of interest to purchasers and consumers, and their standardization (in prior versions of HEDIS) has greatly increased the value of such information.

In each of these domains, the CPM sought measures that would help purchasers and consumers compare health plans. With the assistance of the members of the TAC, the Committee laid out a series of criteria that defined the attributes that it felt important for measures to possess, both for HEDIS 3.0 and future generations of HEDIS. These attributes fell into three major categories:

- Relevance: Measures had to be relevant to purchasers and/or consumers if they were to be considered for inclusion in HEDIS 3.0. Measures were relevant to the extent that they addressed issues that were known to significantly affect health outcomes, to the extent that those issues were controllable (or at least could significantly be influenced by) the health plan, and to the extent that there was evidence that purchasers and/or consumers would use that information in selecting a health plan.

- Scientific soundness: Measures had to be scientifically sound for the CPM to have confidence that the information produced through measurement would lead to better decisions. To be sound, the Committee sought measures that were reproducible (i.e., that produce the same results when repeated in the same populations and setting), valid (i.e., make sense logically and relate to other measures looking at the same aspect of care), and accurate (i.e., measure what is actually happening). Measures also had to have sufficient statistical power to detect differences of the magnitude expected between health plans (or the measures would not be useful for comparison), and had to include a strategy to adjust results for other factors (such as characteristics of the health plan population) that might lead to measured differences in health plan results.

- Feasibility: The CPM was interested in producing a measurement set that was useful in 1996. While it was unwilling to be tightly bound by the limitations of current information systems—an explicit objective of the CPM was to use HEDIS measures to stimulate improvements in those information systems—it was also clear that those potential HEDIS measures that were easy to produce would be of most value in the short run. In order to be feasible, a measure needed to be precisely defined in order to collect data in the same way; it had to be possible to produce the measure at a reasonable cost; and the collection of data for the measurement could not threaten the confidentiality of any patient information.

The CPM recognized that few available measures would be likely to have all of these attributes to the fullest extent, but agreed that the longer term requirements for HEDIS measures should be established and communicated. More than that, the Committee used these attributes to guide its evaluation of potential HEDIS measures, and to identify issues that could be resolved empirically where measures fell far short. This, of course, was part of the genesis of the HEDIS 3.0 Testing Set.

These domains, and these attributes, were summarized in December 1995 in the CPM's Public Call for Measures. That solicitation went out to more than 1,700 organizations; by March 1996, 826 measures (in various stages of development) came to NCQA. The value of this approach is that we now have a very good sense of the scope and depth of existing performance measures, and it enabled the CPM to cull the best from that mix.

The final format and presentation of HEDIS 3.0 also represent a change from earlier versions. The document is contained in four separate volumes. The first volume includes a history of HEDIS, and a narrative on the development and contents of HEDIS 3.0. The second volume contains the technical specifications for collecting and reporting HEDIS 3.0 data. Volume Three contains NCQA's Member Satisfaction Survey, the standardized member satisfaction instrument employed in HEDIS 3.0.

And, since HEDIS 3.0 will undoubtedly drive health plans to invest in enhanced information systems with which to capture data and track performance, Volume Four comprises a "road map" for the development of those information systems, complete with challenges and near- and long-term milestones that would be associated with the greatest gains in performance measurement over the next 10 to 15 years. Once all four volumes are printed, NCQA will make all them available to the Subcommittee.

NEXT STEPS FOR HEDIS

HEDIS 3.0 will remain the standard in performance measurement until at least 1998, the earliest date a significant revision might be released. But the CPM's process will outlive 3.0 to assure that HEDIS continues to evolve and improve. As it has already, the CPM will periodically define the important issues for which we need information, and will issue periodic calls for new measures to address those areas. It will evaluate those new measures as it has already done—systematically, scientifically, and in collaboration with outside experts. But the CPM will have available to it a richer universe from which to draw—for the Testing Set will be a resource to the CPM for measures that have been cultivated specifically for the purpose of health plan comparison. And—as NCQA works with others to stimulate the development of completely new measures, in areas where there is currently nothing yet even for testing—the field from which to draw will grow even larger and richer. This process predicts a HEDIS set that will continually improve, and that will remain responsive to purchasers and consumers of health care.

Chairman THOMAS. Thank you very much.
Mr. MacDonald, of the private sector.

STATEMENT OF J. RANDALL MACDONALD, SENIOR VICE PRESIDENT, HUMAN RESOURCES AND ADMINISTRATION, GTE CORP.; ON BEHALF OF CORPORATE HEALTH CARE COALITION, AND ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS

Mr. MACDONALD. Thank you, Mr. Chairman, and distinguished participants. Good afternoon.

I am Randy MacDonald, senior vice president of human resources for GTE Corp. Thank you for the opportunity to speak about the importance that GTE places on quality health care. We cover over one-quarter-of-a-million GTE employees, retirees, and dependents in 50 States.

I am testifying on behalf of the Corporate Health Care Coalition and the Association of Private Pension and Welfare Plans.

We welcome Medicare's effort to become a more prudent purchaser of health care on behalf of its 38 million beneficiaries, which also includes just about 35,000 GTE retirees.

Employers that are aggressive and responsible purchasers of health care services are, indeed, in the best position, as clients, to demand information, accountability, and quality improvement from health plans. Employers have been leaders in defining, measuring, and achieving quality health care improvements in recent years. As Medicare transitions from a large fee-for-service program to a public purchaser of health care services, it is critical, it is important, to develop standards in cooperation with the success that we've had to date.

We urge that any legislation Congress considers encourage collaborative efforts and not preempt them or establish conflicting requirements.

GTE spends more than \$500 million each year on direct health care costs, and we estimate an equal amount in time lost by people who are missing work. It is in our own enlightened self-interest to have healthy employees not away from the work site because the health care system has failed them.

GTE has been successful in improving health care by bringing information, measurement and accountability, health care plan choice, and employee education to the process through cooperative working relationships. That start with our employees includes the unions that represent certain of our employees, the CWA, and the IBEW. Every GTE employee may choose a traditional fee-for-service or point-of-service plan. They can select the plan that will let them see any doctor they choose. Additionally, we offer staff and IPO model HMOs, where they are available.

I could not disagree with Dr. Vladeck any more strongly, that corporations are forcing employees into managed care arrangements. In the last 6 years, more than 65 percent of our employees voluntarily chose health care plans that were managed care plans. And employee surveys have found that satisfaction with managed health care is higher than with the traditional fee-for-service plans.

We believe that high employee satisfaction is directly related to the high quality and the higher level of benefits that managed health care plans offer. We require health plans to obtain independent accreditation, and we have joined other national employers and HMOs to develop data reporting processes to measure health plan quality and member satisfaction, known as HEDIS.

In addition, we work directly with the health plans to improve the plan quality. We bring plan executives together in regional quality improvement conferences. We openly exhibit the names and the HEDIS reporting data for competitor plans, as well as for the best plans in the country. In other words, we give them their grades right in front of the competition. We focus on identifying best practices and urge the best plans to share their insights and methods with the others.

We now have very good evidence that the better quality plans actually cost less. Our experience is that higher quality drives down cost.

GTE holds health plans accountable in ways that does not interrupt the doctor-patient relationship and focuses on the medical necessity and appropriateness.

A key to quality is insisting that only physicians make medical decisions. We believe that neither private nor public health care purchasers should mandate medical practice. If a plan fails to meet our performance standards, we share our findings directly with the plan and we solicit corrective actions. If the plan does not make sufficient progress, we freeze any new enrollments. The final step is we discontinue the plans when problems exist. To date, we have done that in 14 cases.

We also believe in educating our employees about health care plan options. During GTE's annual enrollment, which is "open season" for the Federal employee program, we prepare extensive mailings summarizing the health plan options available. GTE's health plan factsheets tell whether the plan has received external accreditation, if it has GTE benchmark status as one of the better

combinations of quality and overall cost effectiveness in each local market, and whether the plan has attained HCFA's highest rating nationally, the "exceptional quality designation" offering the highest health care quality and patient satisfaction. Consumer information and consumer choice bring our employees into the health care selection process.

We fully support HCFA's recent efforts to use its market influence in health care purchasing. Four recent examples of those efforts are noteworthy.

First, HCFA's leadership in the Foundation for Accountability, a collaboration of private and public sector purchasers to focus on health care outcome measures.

Second, requiring plans to report performance standards using HEDIS 3.0, to allow insight into provider access, member satisfaction, and medical outcomes.

Third, refusing to contract with plans that include a gag rule; and fourth and finally, notifying health plans that they cannot limit services to predetermined settings, such as outpatient care.

HCFA's role as a health care purchaser improves the market-based initiatives we believe in. We believe HCFA can do more, exercising leverage and demanding improved data and cost and quality, developing standardized methodologies, and maintaining commitments to those standards, along with the private purchasers.

We encourage government plans to work with us, the private sector, in their role as a purchaser, rather than as a payer or regulator of health care. We believe quality managed health care has been crucial to our ability to control cost increases, while improving health care quality.

Again, thank you for the opportunity to speak.

[The prepared statement and attachment follow:]

Statement of J. Randall MacDonald, Senior Vice President, Human Resources and Administration, GTE Corp.; on Behalf of Corporate Health Care Coalition, and Association of Private Pension and Welfare Plans

Chairman Thomas, members of the subcommittee, and other distinguished participants: good afternoon.

My name is J. Randall MacDonald. I am Senior Vice President-Human Resources and Administration for GTE Corporation. We at GTE share your commitment and interest in health plan quality and thank you for the opportunity to speak about the importance GTE places on quality healthcare and the benefits to our 85,000 employees, 55,000 retirees, and their dependents. We also welcome this hearing today and its focus on Medicare's efforts to become a more prudent purchaser of healthcare benefits on behalf of its 35 million beneficiaries, including the almost 35,000 GTE retirees and dependents who are covered under the Medicare program.

GTE is one of the largest publicly held telecommunications companies in the world with revenues of \$21.3 billion in 1996. GTE is also the largest U.S.-based local telephone company and a leading cellular-service provider with wireline and wireless operations that form a market area covering more than one third of the country's population. GTE also is a leader in government and defense communications systems and equipment, aircraft-passenger telecommunications, directories and telecommunications-based information services and systems.

GTE has employees and retirees in every state. We are offering healthcare benefits on a nationwide basis.

I am testifying today on behalf of both the Corporate Health Care Coalition and the Association of Private Pension and Welfare Plans.

The Corporate Health Care Coalition is a group of twenty-two multi-state, self-insured companies that joined together in 1993 to represent the concerns of large corporate purchasers of healthcare benefits. Member companies operate health benefit plans for four million employees, retirees, and their families and provide over \$7.5 billion in health benefits each year. Coalition members have been in the fore-

front of efforts to ensure high-quality, cost-effective healthcare and are a major force in on-going private sector efforts to improve the healthcare delivery system through provider accountability.

The Association of Private Pension and Welfare Plans (APPWP) is the national association of firms and individuals concerned about Federal legislation and regulations affecting employee health and pension benefit plans. APPWP's members include Fortune 500 companies, managed healthcare plans, and consulting and actuarial firms. The association's member companies and organizations sponsor or provide services to health and retirement plans covering more than 100 million Americans. APPWP has also recently established the Center for Employer-Sponsored Health Care to promote a better understanding of market-driven health care reform and the public policy alternatives to support the voluntary employer-based system.

This testimony describes several initiatives GTE has taken to monitor and improve health plan quality. We believe that one of the most important keys to the success of these efforts is to bring information, measurement, accountability, and health plan choice through cooperative working relationships that begins with our employees, including the unions that represent certain of our employees the Communications Workers of America (CWA) and the International Brotherhood of Electrical Workers (IBEW).

As Medicare enters the transition stages of being a large fee-for-service program to a large public purchaser of the services of private health plans, we believe that Medicare will need to form similar partnerships with Medicare beneficiaries, health providers, and health plans. However, there is one other important partnership to keep in mind. Because of the enormous market influence that Medicare will have on health plans as it develops further quality standards, it is important that its standards are developed in close cooperation with private health plan purchasers who have been the leaders in defining, measuring, and achieving improvements in health quality over the past several years. Similarly, we urge Congress to recognize the importance of employers and public purchasers working together to achieve our common goal of improving health plan quality. Specifically, we urge that any legislation you consider should encourage such collaborative efforts and not preempt them or establish conflicting requirements through legislation or regulation.

Now let me explain what we are doing at GTE to address health plan quality improvement.

GTE AND THE HEALTHCARE COMMITMENT TO EMPLOYEES

GTE spends more than \$500 million each year on direct healthcare costs. And, we project a similar additional cost in lost time or lower productivity because of health problems of employees or family members. It is in our own enlightened self-interest to have healthy employees at work and not away from their work site because the healthcare delivery system failed to recognize the patient's medical condition early enough or did not provide the appropriate treatment.

Every full-time and eligible part-time GTE employee may choose a traditional fee-for-service or point-of-service plan. Every GTE employee can select a plan that will let them see any doctor they choose. Additionally, where quality managed care plans are available, we offer them including both Staff and Individual Practice Association (IPA) models.

In this employee choice environment, more than sixty-five percent (65%) of GTE's employees have voluntarily chosen managed healthcare plans in 1997. We believe GTE employee elections reflect the quality and value of the plans we offer to them. The plan quality and performance information we evaluate and provide to our employees enables them to make informed choices.

QUALITY, COST-EFFECTIVE HEALTH CARE

Developing strategies and programs to control healthcare costs by actually improving employee health is a business imperative. Beyond the business reasons, GTE has a commitment to employees and retirees to offer quality services through all our employee benefit programs and we have taken steps to control cost and improve quality. The cornerstone of GTE's healthcare strategy efforts is the well-being of all participants and the source of that well-being is quality healthcare.

GTE believes that the objectives of controlling cost and improving quality can be achieved and that these dual objectives are fortunately linked not mutually exclusive. We believe that driving quality up drives cost down.

Historically, we and other employers have focused on administrative costs, negotiating with health plans to improve administrative efficiencies, and negotiating competitive profits or margins. While those efforts continue, at GTE we have in-

creased our efforts to measure and positively influence the actual delivery and quality of healthcare services.

Everyone has their own individual definition of quality healthcare. For some, it is the level of comfort between the doctor and the patient, while others may be more concerned with a physician's credentials. GTE's concept of healthcare quality encompasses the accessibility of care, the adequacy of services provided, the cost-effectiveness of the care, the patient's satisfaction and, most importantly, the resulting health status of the patient.

We believe our success has been based on making health plans accountable through contracting terms for the quality and cost of the healthcare they provide to their members and to our employees. We solicit competitive proposals in each market based on the key attributes including access, demonstrated quality, member satisfaction, organizational and financial stability, and cost. In today's competitive healthcare environment, we select the best health plans while encouraging continuous quality improvement by both the plans selected as well as those that were not.

A commitment to quality healthcare in a cost conscious environment requires an understanding of what defines quality and how to measure quality improvements. Only then can employers better understand a long term strategy while introducing accountability for health plans and healthcare professionals.

Accountability is critical to the quality improvement process. That accountability requires establishing trust among three affected parties:

- Employers that may have been viewed as exclusively focused on cost;
- Our employees who become health plan members and patients of healthcare providers; and
- Medical delivery systems and providers.

Only in an atmosphere of trust, dialogue, and information exchange can we work together to improve quality and the medical outcomes and patient satisfaction that will result.

The move to quality measurement, improvement, and accountability helps everyone. The healthcare quality movement born from the Total Quality Management (TQM) theories prevalent in business today started as one method to address the need of employers to control healthcare costs. Given the numerous health plan alternatives available to our employees, information was needed to help select the best options available with respect to cost, the quality of healthcare delivered, and patient satisfaction collectively what we define as value.

Additionally, developing and implementing quality measurement helps medical professionals improve their practice of medicine by enabling direct, age and severity adjusted comparisons to other healthcare delivery alternatives. The data now permit doctors or plans to measure themselves directly against the best in their geographical market, or the best in the country. There is a direct comparison to GTE's telecommunications business. GTE can no longer compare our performance with our historical competitors in each local market we serve. Global competition requires that we strive for "best in class" performance.

QUALITY HEALTHCARE AT GTE

GTE's primary healthcare objective is the same as any other of GTE's major expenditures: to ensure that we are receiving value for the money we are spending. GTE started to influence plan selection by our employees based on cost because that was our primary interest and was the only information available. However, we quickly realized that cost alone was not sufficient. We recognized that value includes measurement of cost and the quality of services provided.

To GTE, healthcare value begins with two important criteria for health plans or organized healthcare delivery systems. First is external health plan accreditation from organizations such as the National Committee on Quality Assurance (NCQA), an independent, not-for-profit organization that accredits managed healthcare plans. Plans offered by GTE must have either achieved external accreditation, or be committed to and actively working toward application and review. GTE actually took steps to terminate a "prestigious" plan that did not take this requirement seriously. GTE insisted, and after a thorough discussion, the plan sought accreditation.

Of equal importance is a health plan's ability to track and report what has historically been individual patient treatment in a standardized, and therefore comparable, format. GTE joined with other national employers to develop and implement a data reporting process that became the Health Plan Employer Data and Information Set (HEDIS) to measure health plan quality, quality improvement, and employee satisfaction with the healthcare benefits that we offer. Standardized reporting is critical as it enables consumers to identify variations.

As with any reporting and measurement system, there are those that believe that NCQA and HEDIS in the current form are inappropriate or, at a minimum, not sufficient. GTE has found NCQA and HEDIS to be important contributors to health plan evaluation and we also recognize the need to continually enhance and improve these measurement systems. NCQA and HEDIS are committed to improving the construct of future evaluation systems and the resulting improvements in healthcare delivery. We believe the concepts of external accreditation and plan reported performance measures offered by NCQA and HEDIS are critical to improving healthcare delivery and ensuring quality is not compromised.

Further, GTE's staff conducts rigorous on-site reviews with the medical and administrative leaders of the HMOs, facilitates employee feedback, monitors patient experiences and concerns, and conducts independent satisfaction surveys.

QUALITY IMPROVEMENT PARTNERSHIP CONFERENCES

GTE regularly brings health plan executives together in regional Quality Improvement Conferences. At these meetings, we openly exhibit the names and HEDIS reporting for competitor plans, as well as for the best plans in the country. That is, we give them their "grades" right in front of their competition! We engage the medical directors in pro-active discussions about our evaluation process as well as how they can improve their plan's performance. These sessions include case studies of process and clinical changes adopted by health plans, and how such changes are improving the plan's cost structure and member satisfaction.

We ask the plans that attend to identify one or two specific concerns for focused, collaborative attention with the commitment to provide follow-up analysis to measure changes and clinical improvements. Current health plan driven initiatives that have come out of these Quality Improvement Partnership sessions include a review of the treatment for low back pain in Boston, women's health issues in Tampa, and a project focused on the detection and treatment of breast cancer in Portland, Oregon.

Health plans have not previously worked collaboratively and have certainly not shared their strengths and weaknesses. Our efforts are focused on identifying the best medical practices and engaging the best plans to share their insight and methods with others.

Quality improvement also enhances the trust and satisfaction of patients. Quality improvement and measurement systems will result in improved benefits to patients and employers that are concerned about the health status, productivity, and cost of healthcare for their employees. Measurement systems will lead to increased market share for those health plans that can best demonstrate the combined attributes of quality, cost effectiveness, value, and patient or member satisfaction.

GTE is committed to supporting efforts to continually improve the availability of health plan quality data, especially regarding outcomes, while preserving individual patient confidentiality. Ultimately, the best data collection will enable us to determine which plans keep their members the healthiest. Similarly, identifying the "best practices" used in those plans, and encouraging other plans to adopt them, will drive up quality throughout the healthcare delivery system and thereby increase the quality of healthcare for all of us.

LONG TERM HEALTHCARE PARTNERSHIPS

GTE holds health plans accountable in a method that makes sure that medical practitioners have the flexibility to do what is medically necessary and appropriate for their patients. We believe that neither private nor public health care purchasers should be in the position to mandate medical practices' patterns. When our employees have questions or concerns, we ask that both guidelines and specific clinical cases be reviewed by the best medical practitioners in the country to provide the patient with specific clinical findings regarding the proposed treatment, including whether such treatment is within the medically appropriate coverage provided by their health plan.

Healthcare is a long-term, "lifetime" concern for our employees and their dependents. GTE continues to go to great lengths to assess and partner with the health plans we offer to ensure that the plans operate above our quality standards. Partnership is a process where all parties learn from each other to drive continuous improvement.

If a plan fails to perform at or above our performance standards we initiate efforts for improvement by first sharing our findings directly with the plan and soliciting their review and corrective actions. Additional steps include notifying our employees of such problems and, if not corrected, "freezing" any further or new enrollment. The final step of discontinuing offering a plan is disruptive to our employees and is only

considered when quality and cost problems persist and higher quality alternatives are readily available.

LINKING COST AND QUALITY

GTE has distinguished itself in pursuing quality as a major driver in long term cost management. We have learned in the process that the best plans with respect to quality are typically also those that are among the lowest cost, and certainly among those with the lowest rate of annual cost increase. We have very good evidence that the better quality health plans actually cost less; that improved quality drives cost down.

We believe this quality/cost formula is derived from several contributing factors:

- Our leadership position in the marketplace. We have been able to engage health professionals in a meaningful dialogue to improve patient access and medical care services;
- Insisting on good techniques for preventive and early treatment of acute medical conditions when both diagnosis and treatment are less expensive; and
- Medical management to ensure the most-appropriate medical treatment for each patient.

For example, our initial work with health plans focused on improvement in the mammography screening rates for women. The improved analysis, contributed by one of our health plan partners, also focused on the stage of breast cancer detection. Health plans recognize the medical, economic, and patient satisfaction benefits of early detection and early treatment.

CONSUMER EMPOWERMENT

GTE employees and retirees are provided with a variety of healthcare options, including traditional fee-for-service plans and managed healthcare options, if available where the employee lives. Participants may select an option that best meets their needs including more than 125 HMOs out of the approximately 550 HMOs that currently exist throughout the United States. GTE has developed performance requirements for all of its managed healthcare plans including a standard plan design that each HMO must meet.

During annual enrollment, GTE prepares extensive mailings to employees and retirees summarizing the health plan options available to them. GTE's Health Plan Fact Sheets include basic information that our employees have told us they want to know. This includes the type of information employees might tell their family, friends, or neighbors in either recommending or not recommending a health plan such as how long the plan has been in business, the size of the plan's membership, and any differentiating attributes.

GTE's Health Plan Fact Sheets also include summaries of plan-reported HEDIS data that allows our employees to make direct comparisons of health plan alternatives. These summaries tell whether the health plan meets basic standards, GTE's "Benchmark" status as one of the best combinations of quality and overall cost-effectiveness in each local market, or GTE's highest rating, the "Exceptional Quality Designation." Exceptional Quality plans are a select group of HMOs that have been rated as having the very best overall quality of all the plans offered by GTE throughout the country. Health plans that have earned GTE's Exceptional Quality Designation offer the highest combination of healthcare quality and patient satisfaction.

A listing of the twenty-three (23) HMOs throughout the country that are designated "Exceptional Quality" by GTE for 1997 is included as the Appendix of this testimony.

Information helps employees become better consumers healthcare. We believe that consumers will select services and products that are best for them based on value but only if they know the difference between offerings. Comparative information or "Report Cards" help consumers distinguish between products and services that might not otherwise be distinguishable. Perhaps most importantly, consumer information and consumer choice bring our employees into the healthcare selection process. Employees have responsibility for the healthcare choices they make.

At GTE we have gone beyond the historical employer practice of simply listing health plan options by including quality plan ratings. For example, we believe that it is important that our employees know that the Kaiser Foundation Health Plan of Mid-Atlantic States has the highest member satisfaction ratings of plans offered in the metropolitan Washington, DC area.

Most GTE employees and retirees also have an opportunity to attend an annual Health Fair where they can talk directly to health plan representatives about cov-

erage and individual questions or concerns. We want our employees to be informed before they pick a health plan that is best for them and their family.

This multi-faceted evaluation process is the same method most employees use whenever they purchase something for themselves or their family like a house or a car. Consumers may first become aware of new options by media advertising like radio, television, and newspapers. Next, most consumers learn as much as they can by reading or talking to their friends. Finally, the consumers that usually attend the GTE Health Fairs ask direct questions that allow them to compare alternatives.

Our surveys have confirmed that employees and retirees want more information about healthcare alternatives and are willing to act based on that information when the information is both general and personalized. In the absence of data, consumers base their decisions on information they know or can learn from others. Consumer Reports magazine learned long ago that informed consumers have added power in the marketplace.

At GTE, we are moving our Human Resources practices from entitlement to empowerment. Our employees want and need information to enable them to make healthcare decisions that reflect their individual needs and family circumstances. We believe that quantitative and qualitative measures, in a user-friendly, comparative format support informed consumers.

In today's environment, giving employees a "list" of health plans to pick from, without any supporting information, may lead consumers to make uninformed and, in some cases, inappropriate medical plan choices.

We believe our commitment to quality and informed choice by our employees is confirmed by the dramatic increase in enrollment in managed healthcare plans and satisfaction with the managed care plans we offer. In an exhaustive survey of employees GTE conducted with Digital Equipment Corporation and Xerox in 1993 and again in 1995, we polled 25,000 employees on satisfaction with their health plan election. In both surveys we found that satisfaction with managed healthcare plans is actually higher than with the traditional indemnity plan.

Everyone has a responsibility with respect to healthcare. GTE has evaluated multiple options and we offer what we believe to be the best plans available. Further, we have provided consumer-focused information to support informed decisions by employees as to what healthcare option is best for them. Our employees then select the health plan that provides the best value for their individual circumstances: cost, quality, and patient satisfaction.

HEALTHCARE AND QUALITY LEADERSHIP

Employers that are aggressive and responsible purchasers of healthcare services have been in the best position, as clients, to demand information and accountability from health plans and we encourage the Health Care Financing Administration (HCFA) and other governmental purchasers of healthcare to join us. Employers like GTE have established a track record of involvement by identifying, compiling, and utilizing data (with individual patient confidentiality preserved) to improve quality and the overall level of healthcare services. We will continue to work with healthcare systems using the same information management techniques that we apply to every other component of our business.

We fully support HCFA's recent efforts to use its' market influence on health care purchasing. Specifically, we believe HCFA is moving in the right direction in four recent initiatives:

1. Leadership in the Foundation for Accountability (Faact), a collaboration of private and public sector purchasers to focus on health outcomes measures as an evolutionary science. These initiatives will expand health care quality measures beyond process to outcomes and the long term health status of plan members.

2. Requiring plans to report performance on HEDIS 3.0 during 1997. HEDIS 3.0 is also an important breakthrough that will allow insight into medical outcomes in addition to performance measures.

3. Refusing to contract with plans that include a "gag rule" within the contractual or operational agreements with medical care providers. We agree that patients need to be fully information about medical treatment alternatives, including the potential advantages and disadvantages of each. Medical providers should be open to discuss such alternatives with their patient within the patient-provider relationship.

4. Assuring the availability of all medically necessary covered services to Medicare beneficiaries. Rather than accelerate the fears of Medicare participants, HCFA has pro-actively directed health plans that they cannot direct services to a pre-determined setting such as out-patient care, or a restricted length of in-patient stay for treatment of breast cancer. HCFA is following employer-purchaser initiatives that treatment, including the location of services, should be based on the clinical needs

of the patient. This does not preclude out-patient services. Rather it ensures that the needs of the patient will direct the use of the most appropriate resources.

In the rapidly changing health care environment, it is important that all purchasers, and especially HCFA, remain flexible and focused on medical outcomes and not specific medical practice patterns. Each of these initiatives enhances HCFA's role as a health care purchaser that improves market-based initiatives for everyone.

My purpose today was to demonstrate some of the activities that large employers are engaged in are contributing to changes in the delivery of cost-effective, responsible healthcare. It remains an ongoing responsibility to evaluate our results, learn from our mis-steps, leverage our successes, and most importantly, to share our findings with private and public employers, medical professionals, and the academic community, as well as with our own employees.

Over the past three years, GTE has worked with HCFA's staff as well as representatives of other public healthcare purchasers including the Department of Defense to share our experience in the role of healthcare purchaser.

HCFA administrators can enhance our mutual success in improving quality and managing costs by contributing in their role as a "purchaser." This includes:

- exercising leverage and thereby build upon the work of private employers with respect to demanding data, cost, and quality improvements and development of a standardized method to share information with consumers, and

- maintaining a commitment to the development of health plan quality standards and reporting requirements in collaboration with private purchasers and opposing unnecessary or conflicting standards which are proposed through the legislative and regulatory process.

I believe the exemption provided by the Employee Retirement Income Security Act of 1974 (ERISA) to self-insured plans such as GTE's is crucial. ERISA, which exempts such plans from state-by-state regulation or taxation, has been key to enabling our innovation. As I indicated, we offer health plans to employees or retirees in each of the 50 states. If we were subject to state-by-state regulation, the improvements we have achieved might not have been possible.

We all seek the best medical care available for ourselves and for our families. For GTE, "best" means health plans that offer the most appropriate, cost-effective treatment with measurable outcomes that our employees and shareholders can afford.

GTE believes that responsible healthcare reform is being driven by informed purchasers and empowered consumers who select medical services that provide high quality and value while rejecting those that do not. Healthcare quality improvements will benefit health plan members and reduce costs for the health plans. That benefits each of GTE's stakeholders: our employees, shareholders, customers, and the communities where our employees work and live. GTE believes it is effectively achieving the balanced goal of high-quality medical care and employee satisfaction at a fair cost to the company and its shareholders.

Thank you for offering me the opportunity to tell our view of health reform and our efforts to improve and continually evaluate the quality of healthcare.

Appendix

HEALTH PLANS RECEIVING GTE'S EXCEPTIONAL QUALITY DESIGNATIONS FOR 1997

| | |
|--|-----------------------|
| Blue Care Network—Health Central | Lansing, MI |
| Fallon Community Health Plan | Worcester, MA |
| FPH Colorado, Inc. | Colorado Springs, CO |
| Group Health Cooperative | Eau Claire, WI |
| Group Health Cooperative of Puget Sound | Seattle, WA |
| Group Health Northwest | Spokane, WA |
| Harvard Pilgrim Health Care | Boston, MA |
| Health Partners | Minneapolis, MN |
| Health Plus—WA | Mountlake Terrace, WA |
| Kaiser Foundation Health Plan of Georgia | Atlanta, GA |
| Kaiser Foundation Health Plan—Hawaii Region | Honolulu, HI |
| Kaiser Foundation Health Plan of Mid-Atlantic States | Washington, DC |
| Kaiser Permanente—Northeast Region | Stamford, CT |
| Kaiser Permanente Health Plan of North Carolina | Raleigh/Durham, NC |
| Kaiser Foundation Health Plan of the Northwest | Portland, OR |
| Kaiser Foundation Health Plan of Northern California | San Francisco, CA |
| Kaiser Foundation Health Plan of Southern California | Los Angeles, CA |

Lifeguard San Francisco, CA
Matthew Thornton Health Plan Nashua, NH
Physicians Plus Madison, WI
Providence Good Health Plan of Oregon Portland, OR
Scott and White Health Plan Temple, TX
Tufts Health Plan Boston, MA

Chairman THOMAS. Thank you very much, Mr. MacDonald.
Mr. Randall.

**STATEMENT OF DAVID RANDALL, DEPUTY DIRECTOR,
DEPARTMENT OF INSURANCE, STATE OF OHIO; ON BEHALF
OF NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS' SPECIAL COMMITTEE ON HEALTH INSURANCE**

Mr. RANDALL. Mr. Chairman, thank you, and I would like to publicly thank my good friend, Mr. Ney, for that kind introduction.

Mr. Chairman and Members of the Subcommittee, my name is Dave Randall. I'm the deputy director of the Ohio Department of Insurance. My testimony today comes on behalf of NAIC, the National Association of Insurance Commissioners' Special Committee on Health Insurance.

On behalf of the NAIC Committee, which is comprised of 42 member States, I appreciate the opportunity to address you this afternoon on the subject of managed care and Medicare.

Several years ago, the NAIC recognized the delivery of health care was rapidly evolving away from fee-for-service arrangements and moving toward managed care arrangements of many types. Most State insurance departments have a principal role in regulating managed care entities and observe the market revolution first hand. Thus, insurance regulators appreciate the need to strengthen consumer safeguards in the managed care area.

Many consumer protections already exist within the NAIC model laws in place in many States. Fifty States have laws regulating HMOs. Twenty-nine of those States have laws based upon or similar to the NAIC's model HMO Act.

To build upon that accomplishment, the NAIC has undertaken an extensive effort to ensure that the health care provided by managed care plans is of the highest quality and includes important consumer protections.

In 1996 the Association adopted five model acts that set standards for managed care plans with respect to quality assessment and improvement, provider credentialing, network adequacy, grievance procedures, and utilization review. Together, these models address the issues most significant to health care consumers today, and create a comprehensive regulatory structure for managed care health plans regulated by the States.

As with all NAIC model acts and regulations, these were developed in an open process with the input of consumers, health insurance and managed care industry representatives, health care providers, the Health Care Financing Administration, and accrediting organizations. Because the models were adopted by the NAIC just last year, the States have only now begun to consider them. As is the case with all NAIC models, the States are free to modify the

technical guidance to meet individual State needs and those specific to their markets.

In our formal testimony today you will find detailed descriptions of the five model acts relating to managed care standards. In addition, we have provided detailed information on consumer protections in the NAIC model acts governing HMOs, PPOs, and prepaid limited health service organizations.

It is important to emphasize that many of the same provider contracting issues that arise in the regulation of State licensed plans and HMOs also arise in the context of plans governed by ERISA.

The NAIC recommends additional protections for such plans so that consumers of both ERISA-governed and State-licensed health plans have similar levels of security and the ability to challenge any possible unfair treatment by health plans.

The NAIC began developing managed care standards more than 3 years ago as part of a larger comprehensive effort, now known as CLEAR, the Consolidated Licensure of Entities Assuming Risk. Part of CLEAR includes the review of all current NAIC model laws to increase the use of common definitions, and to promote the uniform regulation of health plans and entities that have similar functional characteristics, especially with respect to the assumption of risk.

In my own State of Ohio, we have taken the initiative in drafting legislation to establish a managed care uniform licensure act, along the same lines as the NAIC's CLEAR initiative. The proposed Ohio law recognizes the function as opposed to the structure of these entities, or the acronyms that they go by in the market.

Another facet of CLEAR is the development of a risk-based capital formula for all health organizations subject to State insurance regulation, with the goal of providing more flexible requirements for a health plan's fiscal soundness. Such a formula would offer a method to take into account an organization's unique characteristics and to acknowledge arrangements that either increase or reduce risk, which is also true with our proposal in Ohio.

The States also perform an important role for the Federal Medicare Program. Organizations that contract with the Medicare Program to provide Medicare-managed care services are licensed and monitored at the State level.

Over the past 2 years, the benefits that Medicare beneficiaries and the Federal Government receive from State regulation have been placed at risk. Proposals before the 104th Congress included provisions to exempt provider-sponsored organizations, or PSOs, from State regulation. The NAIC has already expressed its significant concerns about the implication of these proposals, and I wish to reiterate those concerns here today.

There are numerous reasons for our concern. Most notably is the possibility of our most vulnerable populations, the elderly and disabled, being denied the safeguards and protections of State insurance regulation. The States, with over 125 years of experience in regulating the business of insurance, have the regulatory framework and the technical expertise in monitoring for company solvency and providing other consumer protections.

Further, the States are in the best position to understand what fits the needs of their markets and consumers best. We urge you

to recognize the States' accomplishments and their continuing effort to implement innovative and effective protections in the health insurance and managed care marketplaces that exist today.

Again, thank you for the opportunity to testify, and I, too, would be happy to answer any questions you might have.

[The prepared statement follows:]

**Statement of David Randall, Deputy Director, Department of Insurance,
State of Ohio; on Behalf of National Association of Insurance Commissioners', Special Committee on Health Insurance**

INTRODUCTION

Good morning, Mr. Chairman and members of the Committee, my name is David Randall. I am testifying this morning on behalf of the National Association of Insurance Commissioners' (NAIC) (EX) Special Committee on Health Insurance (the "NAIC Committee"). I am the Deputy Director of Insurance for the State of Ohio and the Vice Chair of the NAIC's Regulatory Framework (B) Task Force. On behalf of the NAIC's Special Committee on Health Insurance, I would like to thank you for providing me with the opportunity to address you today.

The NAIC, founded in 1871, is the nation's oldest association of state public officials and is composed of the chief insurance regulators of the fifty states, the District of Columbia, and the four U.S. territories. The NAIC's (EX) Special Committee on Health Insurance is composed of 42 of our members. The NAIC established this Special Committee slightly over three years ago as a forum to discuss federal proposals related to health insurance reform and to provide technical advice on a non-partisan basis to all who sought our expertise.

Over the past three years, the NAIC has undertaken an extensive effort to help states ensure that the health care provided by state-regulated managed care plans is of the highest quality and includes important safeguards to protect consumers. In 1996, the NAIC adopted five model acts, which I will discuss, that set standards for managed care plans with respect to quality assessment and improvement, provider credentialing, network adequacy, grievance procedures, and standards for utilization review. Together, these models create a comprehensive regulatory structure for managed care health plans and health carriers that offer managed care products. The purpose of these models is to protect the consumer by ensuring that carriers and plans which restrict consumers' choice of providers, or use incentives to direct consumers to particular providers, meet certain basic standards with respect to quality.

The NAIC has completed its work on these five managed care models, but a model's provisions only become effective in a state when that state's legislature chooses to enact legislation based on the model. The fact that the NAIC has adopted these models does not mean that they are the law in any state. My discussion of the provisions of the models is not meant to imply that these provisions are now necessarily in effect in the states. As I will discuss below, the NAIC is monitoring the activities of state legislatures to determine which states adopt some or all of these five models. Because the models were only recently completed by the NAIC, the states have just begun to consider them.

In addition to these five new models, the states, through the NAIC, have already developed other model laws and regulations for managed care entities. The NAIC's Health Maintenance Organization Model Act or similar legislation has been adopted in twenty-nine states. This model served a pivotal role in promoting state-level protections for state-regulated managed care plans. The NAIC also has a model addressing preferred provider arrangements and prepaid limited service organizations. These models are discussed in more detail below.

States currently regulate managed care organizations through a variety of statutes and regulations governing health maintenance organizations (HMOs), preferred provider organizations (PPOs), Blue Cross and Blue Shield plans, indemnity health insurance plans with a managed care component, and limited prepaid service organizations, among other types of organizations. Many states also regulate organizations that perform certain managed care functions, including free-standing utilization review organizations.

THE NAIC'S MODEL STATE LAWS GOVERNING MANAGED CARE PLANS

Managed Care Models

Over the past three years, in a public process, the NAIC has developed five model acts for managed care plans to improve existing state requirements. We believe that these models, which the NAIC has recently adopted, address the issues most significant to health care consumers today. These managed care models are: the Managed Care Plan Network Adequacy Model Act; the Health Carrier Grievance Procedure Model Act; the Utilization Review Model Act; the Quality Assessment and Improvement Model Act; and the Health Care Professional Credentialing Verification Model Act. The NAIC has drafted these models to apply to all plans performing managed care functions, regardless of their structure or acronym. Some provisions of these models apply to other health carriers as well. The purpose of these models is to provide a comprehensive framework for state regulation of managed care entities. As is the case with all NAIC models, states are free to modify the technical guidance within the models to meet their needs.

The NAIC recognized that the delivery of health care services was rapidly evolving away from fee-for-service insurance arrangements to managed care arrangements of many types. Because most state insurance departments have a principal role in regulating managed care entities and have observed the market evolution firsthand, insurance regulators appreciated the need to strengthen consumer safeguards in the managed care arena. The newly adopted NAIC models apply significant consumer protections to a wide array of managed care organizations. When appropriate to the structure of the organization, these models restrict the application of certain provisions to certain types of network plans.

In general, the five managed care models are intended to apply to a wide range of managed care entities. For this reason, all the models include the following broad definition of "health carrier": [A]n entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

In addition, all five models define "managed care plan" as "a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier."

The NAIC developed all of the managed care models in a public process in which the working group received and considered significant input from the health insurance and managed care industries, consumer representatives, the Health Care Financing Administration (HCFA), health care providers, and accrediting organizations. The regulators attempted to strike the appropriate balance among the relevant concerns of these interested parties, while maintaining the protection of health care consumers and the assurance of high quality health care as the paramount objectives.

Managed Care Plan Network Adequacy Model Act

Many of the issues relating to provider contracting and consumer protections are addressed in the "Managed Care Plan Network Adequacy Model Act," but several other important issues are also addressed in the other models. I will briefly summarize these models and highlight provisions particularly relevant to health plan quality and consumer protection.

This model establishes standards for the creation and maintenance of provider networks by health carriers and applies to all health carriers that offer managed care plans. It requires that arrangements between participating providers and health carriers offering managed care plans address specific issues set forth in the act. The model also contains requirements for the contracts between health carriers and intermediaries.

Section 5 of the model, which addresses network adequacy, requires health carriers to maintain a provider network that is sufficient in the numbers and types of providers to assure that services to covered persons will be accessible without unreasonable delay. Section 5 also requires a health carrier to file with the insurance commissioner an "access plan" for each of its managed care plans. The access plan must describe the health carrier's network and other specified processes and procedures. The act requires a health carrier to make these access plans—with protections for proprietary information—available on its business premises and to provide them to any interested party upon request.

Section 6 of the model sets forth requirements that a health carrier must address in its contractual and other arrangements with participating providers. For example, it prohibits health carriers from preventing providers from discussing treatment options with covered persons, irrespective of the health carrier's position on the treatment options. It also prohibits carriers from penalizing providers who advocate on behalf of a covered person within the plan's utilization review and grievance processes. Other important requirements and provisions set forth within Section 6 of the model include: a provision requiring the health carrier to establish a mechanism for notifying participating providers of the specific covered services for which they are responsible; a provision prohibiting providers from attempting, under any circumstances, to collect from a covered person any money owed to the provider by the health carrier; and a provision prohibiting carriers from using standards to select providers that would allow the carrier to avoid providers serving potentially high-risk populations.

In addition, the model act contains a requirement that carriers make their provider selection standards available for review by the insurance commissioner. One provision prohibits any inducement under the managed care plan for the provider to furnish "less than medically necessary services" to a covered person. The model also includes: a requirement noting that when a provider's contract is terminated for whatever reason, the health carrier must make a good-faith effort to notify covered persons who are patients of that provider within 15 working days; a requirement that the health carrier ensures that providers treat all covered persons without regard to such persons' status as private purchasers or participants in a publicly-financed health care program; and a prohibition against the health carrier's penalizing a provider for reporting in good faith to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

Section 7 of the model act addresses contracts between health carriers and intermediaries. It requires that intermediaries and participating providers must comply with all the model act's applicable requirements for the relationship between health carriers and providers. The model act specifies that the health carrier retains the statutory responsibility for monitoring the provision of covered benefits to covered persons and that the carrier cannot assign or delegate that legal responsibility to the intermediary. Other provisions of this section establish recordkeeping and related requirements intended to ensure that the health carrier and the insurance commissioner have appropriate access to the books and records of intermediaries. Sections 8 and 9 of the model act contain requirements for regulatory filing and oversight of the health carrier's provider contracts and material changes to those contracts.

The Managed Care Plan Network Adequacy Model Act, like the other four models that I will discuss, contains a drafting note suggesting that states may wish to allow accreditation of a managed care entity by a nationally recognized private accrediting entity as a method of satisfying some or all of the law's requirements. The states have different approaches for accepting or permitting accreditation as a means of satisfying their regulatory requirements, but a number of them do make some use of outside accrediting organizations. The accrediting organizations perform the labor-intensive work of making site visits to health plans. For plans that have networks of providers, which is increasingly common, these site inspections require considerable resources because there are numerous sites to visit. Using the accreditation process for regulatory purposes has both benefits and disadvantages. The state insurance departments face different legal and other constraints in the use of accreditation. But it is a method that states are considering as a way to extend their resources while at the same time fulfilling their governmental responsibility to license and monitor these entities.

Health Carrier Grievance Procedure Model Act

The state insurance regulators who drafted the Health Carrier Grievance Procedure Model Act recognized the importance of providing enrollees with a clear and accessible mechanism for addressing their complaints and appealing health plan decisions. This model contains standards for the procedures used by health carriers to resolve grievances submitted by covered persons. "Grievance" is broadly defined and includes written complaints about the availability, delivery, or quality of health care services, including complaints about adverse determinations made in the utilization review (UR) process. The term also includes complaints about claims payment, handling, or reimbursement issues, or about any matter pertaining to the contractual relationship between a covered person and a health carrier.

The model requires all health carriers to provide a "first level grievance review." These reviews enable a covered person to submit written material to a health carrier, but do not include the right to have a meeting with representatives of the

health carrier. However, the model requires the carrier to provide a written decision within a specified timeframe, generally within 20 working days after receiving a grievance, and the decision must contain certain information specified by the model.

In addition, the model requires a health carrier that offers managed care plans to establish a "second level grievance review" process. A second level review provides a covered person with the option of appearing in person before authorized representatives of the health carrier. If a face-to-face meeting is not practical for geographic reasons, the health carrier must provide and pay for the option of communication between the covered person and the reviewers by technological means, such as a conference call or a videoconference. The health carrier must also provide a written decision containing specified information. The decision must be issued within five working days of completing the review meeting, and that meeting must be held within 45 working days from the time that the health carrier receives a request from a covered person for a second level review.

The grievance model also specifies the appropriate grievance procedures for a complaint involving a UR decision. "Utilization review" is defined in both the Health Carrier Grievance Procedure Model Act and the Utilization Review Model Act to mean "a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities." Complaints involving a UR decision are typically "adverse determinations," defined as a determination by the health carrier that a health care service does not meet the health carrier's requirements for medical necessity or appropriateness. These sections of the Health Carrier Grievance Procedure Model Act are intended to be consistent with similar provisions in the Utilization Review Model Act.

The grievance process established in the NAIC's Health Carrier Grievance Procedure Model Act is a process internal to a health carrier or plan. The model does not require the external review of a grievance by another entity or state agency. However, the model permits, but does not require, states to establish an appeals process in the office of the insurance commissioner or another state agency. In addition, the model provides for an independent review of a grievance in certain situations. Specifically, if a grievance involves a denial of service, which is by definition a UR decision, the model stipulates that the reviewing health care professional or professionals shall not be a provider in the covered person's plan and shall not have a financial interest in the outcome of the review. There is an exception to this requirement in cases where such a health care professional is not reasonably available. The exception would apply if all the qualified reviewing professionals in a geographic area had a contract with the health plan. This situation is not uncommon in small states where there are fewer providers and where a majority of the population obtains health coverage from a few large health plans or carriers.

Utilization Review Model Act

The Utilization Review Model Act requires a health carrier to have a written description of its UR program addressing the issues set forth in the model. A health carrier must file with the insurance commissioner an annual summary describing its UR program activities. The UR program must meet the operational requirements set forth in the model.

One managed care issue of prime interest to consumers and providers is the ability of a consumer to seek the closest and most convenient medical care in emergencies. Consumers and providers are understandably concerned when managed care plans retrospectively deny coverage for emergency care that seemed very justified at the time the services were received. Through the NAIC, the state insurance regulators' recommendation for a regulatory approach to this problem reflected consideration and deliberation of several issues. We weighed the ability of consumers to determine the existence of a true emergency, the health plan's procedures to screen emergencies, and the need to control casual and inappropriate use of emergency rooms. The extensive testimony received by the working group on this issue from representatives of consumers, providers, and plans revealed the importance of this issue to all parties involved.

Section 12 of the Utilization Review Model Act addresses emergency services and specifies a standard to be used by entities that conduct UR activities in making decisions about the coverage of emergency services. The standard requires a health carrier to cover emergency services necessary to screen and stabilize a covered person, without prior authorization of those services, if a "prudent layperson" acting reasonably would have believed that an emergency medical condition existed. In addition, a covered person may obtain from a non-contracting provider within the service area of a managed care plan those emergency services necessary to screen and stabilize the covered person, without prior authorization, if a prudent layperson

would have reasonably believed that using a contracting provider would cause a delay worsening the emergency, or if a provision of federal, state, or local law requires the use of a specific provider. The NAIC working group adopted this standard after much public debate. The model defines the terms "emergency medical condition," "emergency services," and "stabilized."

Another important provision of the Utilization Review Model Act prohibits the compensation to any individual or entity that provides UR services to a health carrier from containing incentives to make inappropriate review decisions. The provision specifies that the compensation of these individuals and entities may not be based on the quantity or type of adverse determinations that they render.

As with its other managed care models, the NAIC developed its Utilization Review Model Act through a public process that included extensive participation from representatives of the insurance and managed care industries; health care provider groups; consumers; HCFA; and accrediting organizations such as the Utilization Review Accreditation Commission (URAC), the National Committee on Quality Assurance (NCQA), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The NAIC's working group made every effort to ensure that our model was consistent with the requirements of these other organizations, to the extent that the working group considered their standards appropriate. There was also participation in the process by consumer representatives who are funded by a specific NAIC program established to ensure the participation of consumer groups at NAIC meetings and in other NAIC activities.

As with all NAIC models, states are free to modify this model to accommodate existing state law and other circumstances. For example, some states may choose to adopt the model as a regulation or may use the substantive provisions of the model, but enact a statute authorizing the health commissioner to regulate UR activities rather than the insurance commissioner.

Quality Assessment and Improvement Model Act

The Quality Assessment and Improvement Model Act establishes criteria for the quality assessment activities of all health carriers that offer managed care plans. It also establishes additional criteria for the quality improvement activities of carriers issuing "closed plans," which are essentially HMO-type managed care plans. The model requires health carriers to develop quality assessment and quality improvement programs and to file a written description of these programs with the insurance commissioner or other appropriate regulatory authority.

"Quality assessment" is defined as "the measurement and evaluation of the quality and outcomes of medical care provided to individuals, groups or populations." "Quality improvement" means "the effort to improve the processes and outcomes related to the provision of care within the health plan."

The model requires a health carrier to include a summary of its quality assessment and quality improvement programs in its marketing materials and to describe them in its certificates of coverage. The health carrier must also make available each year to providers and covered persons the findings from its quality assessment and improvement programs and information about the carrier's progress in meeting internal goals and external standards. In addition, a health carrier must give covered persons the opportunity to comment on the quality improvement process.

Health Care Professional Credentialing Verification Model Act

The Health Care Professional Credentialing Verification Model Act requires all health carriers that offer managed care plans to establish a "credentialing verification" program to ensure that the professionals participating in carriers' managed care plans meet specific minimum standards of professional qualification. "Credentialing verification" refers to the process of obtaining and verifying information about a professional's education, current licensure status, board certification, hospital privileges, and other qualifications. The act requires a health carrier to verify specified credentials when a professional first applies to participate in the carrier's managed care plan and to reverify the professional's credentials at least every three years. The act specifies that the credentialing process is separate from the selection process that a health carrier may use to choose its participating providers. Carriers may use separate or additional criteria to choose their providers. The act also establishes the right of the health care professional who is the subject of the credentialing verification process to review information obtained to satisfy the requirements of this act and to submit corrected or supplemental information.

EXISTING NAIC MODELS AND STATE LAWS GOVERNING MANAGED CARE PLANS

NAIC Health Maintenance Organization Model Act, Preferred Provider Arrangements Model Act, and the Prepaid Limited Health Service Organization Model Act

The NAIC managed care models that I have described expand upon many of the protections within the NAIC's existing model laws and requirements already in place in many of the states. Fifty states have laws regulating HMOs. Twenty-nine states have laws based upon, or similar to, the NAIC's Health Maintenance Organization Model Act. This act includes several consumer protections, including specifications for group contracts, requirements that HMOs maintain a quality assurance program and a grievance procedure approved by the relevant state agency, and confidentiality and insolvency protections.

The NAIC's Preferred Provider Arrangements Model Act contains requirements relating to disclosure, access, and provider contracts to ensure, among other things, that consumers of preferred provider arrangements are informed of differences in benefit levels and that providers are not unfairly discriminated against. The NAIC's Prepaid Limited Health Service Organization Model Act contains protections for enrollees of managed care plans providing a limited number and type of health services, such as dental care services or vision care services. These models have served as the basis for several state laws in these areas.

STATE USE OF THE NAIC MANAGED CARE MODELS

The five managed care models discussed above were recently adopted by the NAIC: two in June 1996 and three in September 1996. The NAIC monitors its models to see which states adopt them.

We know that at least six states have used these models to develop public policy. New Mexico has recently promulgated a managed care regulation that reflects several of the models, including the Health Care Professional Credentialing Verification Model Act. North Carolina has also recently adopted a comprehensive managed care regulation that is based in part on portions of three models: the Managed Care Plan Network Adequacy Model Act, the Quality Assessment and Improvement Model Act, and the Health Care Professional Credentialing Verification Model Act. In the State of Washington, the insurance department has proposed a set of regulations that draw on the Managed Care Plan Network Adequacy Model Act. In Maine a regulation is pending that borrows from the NAIC's Health Care Professional Credentialing Verification Model Act, the Utilization Review Model Act, and the Health Carrier Grievance Procedure Model Act. Delaware and Colorado have also studied the models in their consideration of managed care issues and their development of public policy.

At this time we know of no state that has adopted any of these models by passing the appropriate state legislation. This is not surprising; most state legislatures were not meeting last fall and are only now convening. We are monitoring state legislative activities this year to determine the impact of these five model acts.

In general, these five managed care models build upon the authority already granted to many insurance commissioners under state law to regulate managed care organizations. For example, the NAIC's Health Maintenance Organization Model Act requires HMOs to have grievance and quality assurance procedures. The quality assurance procedure must include a process for verifying the credentials of health care professionals. The Managed Care Plan Network Adequacy Model Act also draws upon provisions of the HMO Model Act that prohibit participating providers from attempting to obtain payment from enrollees if the HMO should become insolvent, and that require HMOs to have a plan for continuing benefits for a certain period if the HMO becomes insolvent.

The NAIC's Utilization Review Model Act builds upon the authority already granted to many state insurance commissioners to regulate UR organizations, but the model provides a more detailed regulatory framework. At least 33 states already regulate organizations and entities that conduct UR. Additional states considered UR legislation during their 1996 legislative sessions. In 22 of these states, the insurance commissioner has the regulatory authority. In the remaining states, the health commissioner is usually the state official having jurisdiction over UR organizations. In rare instances a state official other than the insurance commissioner or the health commissioner has the regulatory authority.

THE NAIC'S "CLEAR" INITIATIVE

The NAIC's Regulatory Framework Task Force (the "Task Force") developed the five new managed care models. This comprehensive effort was part of a larger NAIC effort named "CLEAR," or "Consolidated Licensure for Entities Assuming Risk." In

addition to drafting the new models, the Task Force is reviewing all the current NAIC model laws governing health carriers and other health care issues to increase the use of common definitions and to promote the uniform regulation of health plans and entities that have similar functional characteristics, especially with respect to the assumption of risk. The Task Force is coordinating this review with the work of other relevant NAIC Committees, including the Health Organizations Risk-Based Capital Working Group. Now that work has been completed on the managed care models, the top priority of the Task Force is to analyze the NAIC's other current models and begin the process of consolidating the existing health models and incorporating the new definitions and relevant provisions.

In Ohio, as an example, the Department has taken the initiative of drafting legislation which would establish a Managed Care Uniform Licensure Act. The effort in my state is a direct result of regulatory concerns and issues that were raised as a result of the numerous new arrangements that were being marketed in the health benefit marketplace in the state. This led us to the development of our Uniform Licensure Act. This Act recognizes the function as opposed to the structure of those entities competing in the market and is similar to the NAIC's CLEAR project.

In essence, the Ohio's proposed Act requires that any entity that is assuming an insurance risk would have to meet minimum capital and surplus standards in order to conduct business. Those entities not bearing risk would not have to be licensed or capitalized. Consistent with the CLEAR project, Ohio's legislation seeks to level the playing field. It is designed to create a regulatory structure that makes sense from a functional perspective and that does not merely continue to "pigeonhole" statutes based on the newest acronym in the health care alphabet. This legislation has been sponsored by State Representative Dale VanVyven and State Senator Karen Gillmor and is currently pending in the Ohio General Assembly.

Risk-Based Capital

The NAIC's Health Organizations Risk-Based Capital (HORBC) Working Group is developing a risk-based capital formula for all health organizations that are subject to state insurance regulation. This proposal would provide more flexible requirements for a health plan's fiscal soundness. The working group is establishing a formula that sets minimum capital standards according to the level of risk being assumed by the organization. Such a formula would offer a method to take into account an organization's unique characteristics and to acknowledge arrangements that either increase or reduce risk. This type of formula is already in place for life insurance companies and for property/casualty insurance companies.

Risk-based capital identifies four principal risk elements:

- Asset Risk: The risk that existing assets will decline in value and erode an organization's surplus as a result of that decline.
- Pricing and Obligation Risks (Actuarial Risk): The risk of any mispricing in the setting of premium rates or deviations between assumptions and experience in the payment of claims liabilities. This is the predominant risk for health carriers.
- Interest Rate Risk: The risk of loss due to unforeseen changes in interest rate levels.
- General Business Risk: A catch-all category for the wide range of risks faced by businesses. This may include the risk of assessments, administrative expense overruns, and environmental changes, such as cost overruns.

For health plans, regulators are principally concerned with pricing and obligation risks, often referred to as "actuarial risk." This is the risk that insurers may not have adequate funds available to cover insurance risks.

The American Academy of Actuaries (AAA), which provided technical assistance to the NAIC on this project, presented a proposed HORBC formula to the NAIC HORBC Working Group in June 1996. The HORBC Working Group is now developing a prototype risk-based capital formula. In addition to testing, debating, and reviewing the AAA's proposed formula, the NAIC is also soliciting input from interested parties, trade associations, academics, and health care economists. The comments from all interested parties will be used by the HORBC Working Group as guidance in developing the prototype formula to be used as a practical regulatory tool. As with the life and health and property and casualty risk-based capital formulas already completed by the NAIC, the NAIC's HORBC formula for managed care organizations will be continuously reassessed and refined to reflect changes in the marketplace.

STATE AGENCY AUTHORITY OVER MANAGED CARE ENTITIES

There is some diversity among the states with respect to the division of authority between different state agencies to regulate commercial managed care entities and

products that are subject to state law. Most state insurance departments have significant responsibility for issues relating to consumer complaints and coverage decisions and denials. As is already evident in the First Session of the 105th Congress, these issues are of paramount importance in ensuring consumer protection and health plan quality. Typically, state law will also give the insurance commissioner the responsibility for regulating the financial solvency of an HMO and overseeing the subscriber contracts. In addition, state insurance departments often share jurisdiction over HMOs with other state agencies. State health departments usually have primary jurisdiction for regulating the quality of the clinical services provided by an HMO. Occasionally, an agency other than the health department shares jurisdiction with the insurance department.

This bifurcated approach is reflected in the NAIC's Health Maintenance Organization Model Act. This model requires the insurance commissioner to refer a licensure application to the state's health commissioner for certification of the adequacy of the quality assurance program required by the model as a condition of licensure. (See Sections 4 and 7 of the model act.) This bifurcated approach exists in a majority of states, while in at least 20 states, the insurance department has sole authority over commercial (non-Medicaid) HMOs.¹ In nine of the states represented on the Senate Committee on Labor and Human Resources, the state insurance department shares jurisdiction over HMOs, while in the other nine, the state insurance department alone regulates HMOs. Generally this bifurcated approach has worked well, with each state department contributing its particular expertise to the task of regulating HMOs.

In addition, as the NAIC has previously stated in testimony before this committee, the regulatory framework established by the Employee Retirement Income Security Act of 1974 (ERISA) prevents state insurance departments from protecting beneficiaries of any health plan governed exclusively by this federal law. As you know, ERISA plans that use plan assets to pay directly for health benefits (i.e., "self-funded plans") are exempt from state regulation. These plans may include managed care components, such as a restricted provider network or the use of UR, but not be subject to the states' regulatory purview.

In an NAIC white paper, ERISA: A Call for Reform, and in testimony before Congress over the past year, NAIC members emphasized that all consumers of health care coverage deserve the benefits of certain critical consumer protections. Many of the same provider contracting issues that arise in the regulation of state-licensed plans and HMOs also arise in the ERISA context. The NAIC Committee recommends additional protections for such plans so that consumers of both ERISA-governed and state-licensed health plans have similar levels of security and the ability to challenge any possible unfair treatment by health plans.

In enacting HIPAA, Congress created a statutory scheme that applies certain minimum regulatory standards to both ERISA plans and to state-regulated insurance plans. Congress also preserved the states' ability to go beyond the federal law in the regulation of insured plans. If Congress decides to create some minimum standards for insured plans, the preservation of the states' historic role in insurance regulation and their ability to continue to innovate is critical.

Although state insurance departments lack jurisdiction over self-funded ERISA plans, the departments receive numerous complaints from consumers covered by these plans. We believe that this situation will continue and that inquiries and complaints about a plan's noncompliance with HIPAA's provisions will often come to the state insurance department initially, even though the U.S. Department of Labor has jurisdiction over these plans. We would like to bring to this Committee's attention the issue of monitoring self-funded ERISA plans for compliance with HIPAA and suggest that this is an area where the law's provisions will create the need for additional monitoring and enforcement to protect consumers.

MEDICARE MANAGED CARE

States also perform an important role for the federal Medicare program. Organizations that contract with the Medicare program to provide Medicare managed care services are licensed and monitored at the state level. States may require that the organization's application to the Medicare managed care program, the contract with Medicare, and other related information be filed with the State. The states and HCFA also may communicate with one another when either has a concern about the application or the financial status of an organization.

¹National Academy for State Health Policy, "Emerging Challenges in State Regulations of Managed Care: Report on a Survey of Agency Regulation of Prepaid Managed Care Entities" (August 1996). Chart 1, pp. 11-15.

In 1996, organizations began participating in HCFA's Medicare Choices demonstration project, which is designed to expand options to Medicare managed care beneficiaries and to test different payment methods under the Medicare managed care program. Many of the organizations participating in this demonstration are provider-sponsored organizations (PSOs). To participate in the Medicare Choices demonstration project, HCFA requires that applicants to the demonstration project comply with state laws and regulations. In the absence of state licensure laws, applicants will be expected to have contacted the state to obtain direction on appropriate safeguards to put into place.

Over the past two years, various proposals have been introduced in Congress that included exemptions from state insurance regulation, under certain conditions, for PSOs. These proposals may stem, in significant part, from a lack of understanding of the state licensure process and the benefits of state regulation. We will continue to assist in educating federal officials on the state licensure process and the important role state regulation plays in protecting all consumers, including Medicare beneficiaries.

Both the Clinton Administration's budget proposal and the Congressional budget proposals from the 1995-96 legislative session included provisions relating to PSOs. These provisions included mechanisms for PSOs to be exempt from state regulation or imposed specific requirements on states such as with respect to solvency standards.

The conference report to last year's Congressional budget proposal provided that a PSO could obtain a waiver from state regulation if the state did not meet certain conditions. Further, other organizations, including HMOs, could also obtain a waiver from state regulation if the Secretary of HHS found that a state's laws posed an unreasonable barrier to market entry. At the request of the Secretary of HHS, the NAIC, with input from other interested parties, could be delegated the responsibility for developing non-financial standards, of an uncertain scope, that would apply to Medicare managed care plans. To retain any regulatory authority over a Medicare PSO's financial solvency, the state would be required to apply to the federal government to enforce the federal standards and to be approved through a federal certification program.

In the Clinton Administration's second budget proposal released in the spring of 1996, a state could only retain authority to license PSOs that participate in Medicare if the Secretary of HHS determined that the state complied with a certification and monitoring program established by the Secretary. Under this proposal, the state's standards had to be substantially equivalent to federal standards. The state could impose more stringent standards after 1999 if those standards were approved by the Secretary.

In several letters to Congress, the members of the NAIC Committee expressed significant concerns about the implications of these proposals. We anticipate further communications with you and the Administration on proposals before Congress this session.

All of these proposals on PSOs are troubling for a number of reasons. First and foremost, the proposals presume that, from an insurance perspective, PSOs are substantively different from other risk-bearing organizations. This is not the case. The definitions for PSOs in both last year's Administration proposal and the conference report support the fact that these organizations are structurally similar to state-licensed managed care organizations. These definitions were sufficiently broad to encompass organizations that also met the proposal's definition of an HMO. Moreover, any organization that did not meet this definition of PSO could easily restructure itself to conform to the definition and obtain the special treatment provided for in the law.

Second, the Medicare program serves two of our most vulnerable populations the elderly and the disabled. They may be particularly harmed by exempting the organizations from which the elderly and disabled receive services from the purview of state insurance regulation. State insurance regulation provides a depth of oversight not present in the Medicare program and relied upon by federal regulators. This oversight includes but is not limited to significant solvency regulation. It also includes other elements of licensing laws, market conduct standards, and continuing financial and market conduct examinations.

Each of these activities involves significant investments in time and staff resources. The Medicare program does not currently have in place the resources to duplicate the state regulatory framework. Nor does it have the breadth of experience to perform effective consumer protection for all aspects of health plans. To do so effectively, the federal government would need to make significant investments in an expanded regulatory framework.

Third, the proposals impose federal standards on the states that may be inconsistent with standards that states use to regulate other organizations that serve the Medicare managed care program or that operate in the commercial market. This will result in further segmentation of the health insurance market. And fourth, the federal standards may not be appropriately tailored to a particular state's circumstances.

Proposals to exempt provider-sponsored organizations may potentially jeopardize protections for the elderly and disabled, and require extensive federal outlays. We respectfully suggest that proposed legislation which grants special treatment to provider-sponsored organizations be very carefully assessed in the context of these concerns.

CONCLUSION

For insurance regulators, quality and consumer protections are prime concerns in the regulation of health plans. We believe that the augmentation of consumer protections represented in the NAIC's models, or in state legislation addressing these issues which is tailored to specific state needs, together with the upcoming development of a consolidated licensing scheme, will assure that all state-licensed health plans that finance and deliver health care will be solvent and able to deliver the services promised.

We think that state regulation of managed care entities offers the best method of protecting consumers because of the states' expertise in regulating the insurance market and their ability to fashion legislative solutions that best solve the problems in their distinct markets. We urge you to recognize the states' accomplishments to date and their continuing efforts to implement innovative and effective protections in the health insurance and managed care markets. It is critical that any federal proposal affecting the regulation of managed care plans build upon this expertise and preserve state flexibility.

We also recommend improved consumer protections for the portion of the health plan market governed by ERISA and outside the jurisdiction of state regulation. Further, we recommend that Congress reject efforts to exempt any Medicare managed care organization from the protections provided by state insurance regulation. State insurance regulation complements the Medicare program well. It serves as the most appropriate foundation for an effective consumer protection framework for all Medicare beneficiaries.

We appreciate the opportunity to testify today concerning the activities of the NAIC and the states to address the regulation of managed care organizations. The NAIC looks forward to working with the 105th Congress on issues of mutual concern.

Chairman THOMAS. Thank you.

I will try to go across the panel, but if anyone feels moved about any question I ask, it isn't necessarily directed to the one I ask it to. It's anyone who wants to respond. I might as well start with one that may be self-serving.

Mr. Jones, you looked at the BBA, notwithstanding the fact that it was vetoed by the President, and you indicated that at least it looked like it might be a useful or a relevant framework for reform. We thought we were trying to do as much as we could in terms of not just reducing but reforming. So I want to thank you for that.

Have you looked at the President's plan, or some of the more recent HCFA risk initiatives, and do they merit the same—or do you perhaps feel there is more reduction than reform there?

I don't want to ask you to compare the two. I'm just looking for some response in terms of the way in which we tried to handle some of these problems versus the administration's offering.

Mr. JONES. I think the proposals you heard earlier from Bruce Vladeck, which HCFA has announced, and many of the proposals that seem to be headed for the President's budget, are all steps in

the right direction. Some of them we can quibble about and argue about this way or that.

My major concern is that it's just not near enough, fast enough. That's more than a quibble. I would suggest to you that you just heard from Randy MacDonald another example of what a leading employer does for its employees, and it's not unlike what we heard from the director of CALPERS in our committee, which is the California system, and from Xerox, which is another leading and innovative employer. What we're doing under Medicare and even what we'll do, if amended in some of the ways we're talking about, remains primitive compared to that.

We aren't providing basic information on what the choices are, so people know they're available and have the opportunity to choose.

Chairman THOMAS. My concern is, as we move forward with these standards, the Federal Government is not a small participant in the marketplace. My guess is it would have an amazing impact in the private sector, and if you are going to begin moving in quality standards and you're going to move aggressively in this direction, you had better get it right. That's my belief, because it would have a major impact, if it isn't as right as it could be, and we know that's going to be the case—it's not going to be as right as it could be. But the fundamental question of whether it's right or not, if it creates the proper incentives and direction and choice structures, that's what scares me a little bit.

One, it isn't nearly enough, but two, I don't know if we're moving—I guess I want to talk to Ms. O'Kane a little bit about that as well, in terms of their accreditation process versus HEDIS, because you're really looking for two different things: One is the outcome, and the other is the procedure.

What kind of a comfort level do we have, notwithstanding the inability to move as far or as rapidly as we would like, that HCFA has the basics right, in terms of the direction they're going.

Mr. JONES. Let me just comment briefly and then Peggy may want to jump in on this.

Don't think of our report and my urging quicker movement as meaning more standards. The report does suggest some standards, and we have talked a lot this afternoon about standards. But the big need that we focus on is a much simpler one. It really is what are in these plans, what are they like, how do they operate, how should I, as a beneficiary who has been accustomed to Medicare looking for me and treating me in a certain way, how do I behave in a marketplace where there are competing plans marketing to me, hopefully not knocking at the door, but calling on the phone and urging me to sign up. We're at a primitive stage yet of saying, "How do we do that well?"

Standards, I agree with you. Medicare is such a big force in the marketplace that we have to be careful that they do it right if they lay down a rule because it will have a profound effect on the practices of insurers around the country.

Chairman THOMAS. We have GTE here. I don't know whether they're an exemplary company or a model, but I do think it's interesting that they have people in every State so they have some pretty broad-based practices.

Would you say that GTE, or corporation "x", so that folks don't get concerned, is a more sophisticated purchaser of product than HCFA?

Mr. JONES. There isn't any comparison, Mr. Chairman.

Chairman THOMAS. That may not be sufficient for some people. When you say there isn't any comparison, it could go in either direction. The direction you wish to direct it is which direction?

Mr. JONES. They are a much more sophisticated purchaser than HCFA.

Chairman THOMAS. And I don't know that GTE is the most sophisticated in the marketplace. I assume, if I get to Mr. MacDonald, he'll tell me "of course." That's OK.

My fear is I could bring in 20 other major corporations who are multistate and who have looked at this, who have concerns in terms of the cross profile of employees that you do, and if they're not as good as you, they're getting there fairly quickly because they have to. That's my concern.

I assume you would be supportive of that?

Ms. O'KANE. Could you repeat that, please? I missed—

Chairman THOMAS. The idea that the private sector, notwithstanding the criticisms that are made, is probably far more sophisticated and in the near future is likely to continue to be more sophisticated than what HCFA is proposing, in terms of its assistance, education, and help to purchasers of health care products through Medicare.

Ms. O'KANE. I agree, although I think there's a big role of politics and holding HCFA back from being as effective a purchaser that it could be.

Chairman THOMAS. What does that mean? [Laughter.]

I'm serious. I don't know what it means.

Ms. O'KANE. I think that—

Chairman THOMAS. Do you mean if the President had signed our package rather than vetoing it? [Laughter.]

I wanted to help you out in the direction.

Ms. O'KANE. I think it's a lot easier for—

Chairman THOMAS. Do you want to reconsider your answer to—

Ms. O'KANE. I probably should. "Fools rush in."

I would submit that it's easier for GTE, and the numbers show. They're at least in the double digits, though in a smaller universe. It's easier for a company like GTE or Xerox to say "these are my requirements, and if you don't meet them, you're not going to be here." HCFA, I think, is subject to an any willing provider climate, as Dr. Vladeck stated.

Chairman THOMAS. But we can go a long way toward providing the tools to assist, encourage, and allow for comparison, the analogy to a smart shopper. And to a certain extent I agree, in terms of age and also the socioeconomic level. But, frankly, there are an awful lot of pretty sharp seniors out there that, if they were provided with the tools, they could go a long way toward making a choice themselves.

Ms. O'KANE. Right. And I think it's really important to remember there are different segments of consumers for information.

We have a customer service line and we get many, many calls from consumers, many of them Medicare beneficiaries, who are extremely sophisticated. But you do need different levels of information for different levels of interest.

Chairman THOMAS. True. That just shows you how much we have failed, because we don't even have the basics, let alone an ability to differentiate in terms of the market.

Ms. O'KANE. That's right.

Chairman THOMAS. Mr. MacDonald, if I read your numbers correctly, you've got 55,000 retirees in your program, 35,000 of them Medicare.

Mr. MACDONALD. That's correct.

Chairman THOMAS. By math, what does that mean? There are 15,000 who are between whatever your retirement age is and 65?

Mr. MACDONALD. Not only are we the leading employer in managed care, but we have wonderful pension plans. [Laughter.]

Chairman THOMAS. Of the 15,000 who are retired but not age eligible for Medicare, would GTE be interested in entering into a relationship with the Federal Government, so that those folks who have found a home in an enlightened corporation could continue seamlessly in terms of their health care in place of employment, not only when they retire under the age of 65 but also after 65, if we promise not to leave you holding the bag? That is, it would be a passthrough arrangement on the finances, so that the folks who like you and stay with you and are focused toward the GTE family could continue to do so.

Mr. MACDONALD. I think that is a very insightful thought process, into trying to look at a collaborative effort as that transition occurs for those people.

To your point before, about is GTE any better than anyone else, I'm sure there are a lot of companies that are equally as good as what we are trying to accomplish. We did not corner the market. I think the difference is that we are genuinely interested in trying to have collaborative efforts with the government.

From the standpoint of your point, about the government provides enormous leverage in the marketplace, if you combine that with the private employer experience, where we've had enormous success, that becomes extremely powerful.

An example of that is that we have enormous leverage, for instance, in the Tampa, Florida, area. We have not only thousands of employees in that particular area, but as you would guess, thousands of retirees. We can go in and create significant demands on what we expect in the way of managed care.

But if we were to partner with the Federal Government and going in and establishing those standards and those quality measures, it would be enormous. So to your point about partnership, Yes, I think it's very appropriate.

Chairman THOMAS. It may have been an insightful thought, but I can tell you, when I made the offer to the employees when we were putting our package together, I insighted nothing but a riot out the door, in terms of people wishing to enter into an arrangement in which they may wind up—and I fully understand—holding the bag.

Interestingly enough, the one group that did think it was something not only thoughtful but that they might be interested, were the Taft-Hartley unions, because they found themselves apparently somewhat similar to you, in that they have a lot of folk who are retired at around 55 and they wanted to keep that emphasis on the union family and give them support services as they move through not only their employment retirement but then into the Medicare age retirement category, and they thought it would be a good idea to create a seamless transition. So I may sit down with you at some point and figure out how we can create some assurances.

It just seems to me it's a shame that, if you do have a good program, you do like it, and the employer is showing social responsibility, you have to break that link when they reach 65 to go into something that isn't the same and may not be, in their estimation, as good, when we could create a seamless arrangement and you could benefit.

If you're in all 50 States—I believe you mentioned there were 14 cases of termination. Did you find a pattern to those? Did they tend to be predominantly in certain States, or were they almost random, in terms of the situations that occurred?

Mr. MACDONALD. I would say they were random.

Chairman THOMAS. And in dealing with States as you have done in every one of the States, is there a range of competency among the States, or do they all seem to group themselves up near the excellence level?

Mr. MACDONALD. Why don't I want to answer this question?
[Laughter.]

Chairman THOMAS. Let me put it another way. Your employees are located in States with very large populations, diverse economies, and other States that perhaps don't have large populations and don't have diverse economies. Some of the States could be labeled more wealthy on a per capita basis, and so forth, and so forth.

In that arrangement, do you find differences between States, either in terms of sophistication of an understanding of the products you're dealing with, or in their willingness to be cooperative, to help you move in the direction you want to go, or in their professionalism, in terms of how the timelines are handled in giving you what it is that you think you need as an employer?

Mr. MACDONALD. Frankly, because of a lot of the ERISA arrangements that we have, as well as the way we tend to focus on health care, literally working with the States is not a significant problem for us. So I think it's important to keep that in perspective.

I will tell you that in the smaller, closed communities, perhaps where we are in the West, the Southwest and the South, Southeast, in certain closed communities there is a significant reluctance on the part of the providers to look at these types of arrangements. In fact, in reality, in a couple of cases we have actually intervened and created our own arrangements because we could not get insurance carriers, managed care arrangements, to work. Therefore, we created our own managed care arrangements.

Interestingly enough, that leverage, over time, began to focus the market differently.

Chairman THOMAS. And therefore, any effort we have to move toward provider-sponsored organizations or provider-sponsored networks, in which we change the way in which folk can get in and rearrange the game, would be something that you would look forward to because it would create receptiveness to the kinds of things you're doing?

Mr. MACDONALD. It would be yet another lever that one could consider.

Chairman THOMAS. You mentioned ERISA. Would you like to see broader, deeper scope involvement of the Federal Government in dealing with these questions? I'm sorry we sat you two together here at the table. [Laughter.]

Mr. MACDONALD. With respect to my colleague, in its simplest terms, I'm not sure I want to sit before you here and suggest that I want to see a lot of government intervention, period. But the reality of it is that ERISA, if it did not exist for a corporation like GTE, we could not have done what we did. We just couldn't do it State by State. We would not have the resources and we would not be able to deploy both the financial and the human resources that occur. So in our case that has become a very important ingredient.

Whether you add on to that and provide greater flexibility, greater protection, I think that's all a matter of dialog. We would have to examine in each and every instance to see what that may do for corporations such as ours.

Chairman THOMAS. I'm ignorant on this point and that's why I'm asking the question.

You operate in a number of different communities, different States and so on, and you have different health programs. To what extent do you have variation between the programs by geography rather than by corporate design?

Mr. MACDONALD. We have a corporate design both for our indemnity plans, the traditional fee-for-service, as well as when we go in for accreditation with managed care arrangements, HMOs, if you will. We have a standard design we look at as a minimum that they have to meet. So, in reality, we're looking at a national design.

Chairman THOMAS. So your goal is to take your standards and, to the best of your ability, create or impose them on the structure that's there because you believe that's what your employees deserve and should get?

Mr. MACDONALD. Unequivocally. We also believe they deserve a lot of the information that goes with that decisionmaking process, because it's quite interesting to us on how clearly they have become a conscious consumer, and because of that type of information.

Before there was a statement made—and I don't want to make this into a personal thing—but I was curious about the issue of fraud within Medicare. It's interesting perhaps because of my own training and because of my continued closeness with my parents. My parents are in their late seventies.

My mother had a hip operation last year, was billed for some things, and just picked up the phone herself and called and said, "I didn't get these" and stood her ground. She called me up and began to complain about why am I not taking care of the health system. The point of the matter is, if you have an educated consumer, they're going to focus on that.

Chairman THOMAS. Absolutely.

One last question about that, then. If, in fact, you have an ever-more educated consumer and you're providing them with those materials, if you could, for example, negotiate a price structure within the community in terms of a number of providers, notwithstanding the structure of an HMO or otherwise, have you considered the idea of providing cash to your employees, with a catastrophic insurance backup, and allow them to go out with a price list and negotiate prices with providers in terms of what they may or may not want?

Mr. MACDONALD. On an individual basis?

Chairman THOMAS. Certainly.

Mr. MACDONALD. I don't find that completely disruptive to my thinking. The answer to your question is, We haven't done it on an individual basis because, frankly, we believe there's leverage in the mass. The reality of it is that we have defined contribution plans for a number of things, so that if you created a defined contribution plan for medical arrangements, perhaps.

Frankly, I think they just don't have—if I gave them cash, I would also have to give them a lot of information, because for me—

Chairman THOMAS. I thought you were.

Mr. MACDONALD. Well, no, no. What I'm saying is, I have to give them a lot of information to ensure that, on an individual basis, they can create that negotiation.

You have to remember one other thing. If you bring an employee—

Chairman THOMAS. I'm not talking about a negotiation. It just seems to me that even if the Federal Government piggybacked on the Fortune 500, or Fortune 200, and took your prices—not what a smart buyer as the government could do, because I don't know that we'll ever be a smart buyer—negotiate those prices, require them to be available, and you simply have a list of what's available, and then let people go out and do the shopping off of the list. You use your clout to negotiate the lower prices, but allow them to go out and do what they want to do.

It's a hybrid I haven't seen, frankly, but it seems to me, as we move toward more information for individuals, using combined clout—if we took the average of what the Fortune 200 paid for various procedures and the rest, and said this is the list, I've got 300,000 folk over here who will participate at that price, that kind of arrangement changes the marketplace, I would think, significantly.

Mr. MACDONALD. I misunderstood your point, and I apologize for that.

Chairman THOMAS. That's all right. A lot of people do. You're not the first.

Mr. MACDONALD. I know the feeling. [Laughter.]

I think that clearly informed choice is a real appropriate mechanism. Giving people choice, to me, is fundamental to allowing them to have a comfort level of what they're doing.

For instance, we have just recently begun to look at medical care risk HMOs. We are right now conducting focus groups throughout the country, about whether or not our retirees would go to that.

Their whole interest there is, if GTE is willing to acknowledge a quality approach to that particular HMO, they're willing to migrate to that.

Now, that's voluntary. We are also saying to them, If you go over there and you don't like it, come on back. That's the concept of flexibility. That's where you're going to ultimately get people to buy into the system.

Chairman THOMAS. The problem, of course, is when you talk about choice, you have to add reasonable and viable options. We heard in terms of home health care under managed care that it averages about \$800 a year; fee-for-service, it's \$3,400. People are wondering why they're leaving the managed care for home health service to the fee-for-service. It's pretty obvious.

Mr. MACDONALD. I am making those assumptions.

Chairman THOMAS. So our problem is, we don't have a measurement tool that allows us within a range to talk about comparable quality with roughly comparable prices right now, and that's what concerns me.

Mr. Randall, I don't want to try to direct particular questions to you, and I know the States are making great strides. I think I indicated earlier that I'm hopeful the NAIC is going to give us a tool based upon some experience that some of the more progressive, if I could use that term, States are using, in terms of evaluation.

But I think you still acknowledge there are differences between States, simply in terms of their size and ability to do a job, which is becoming more and more sophisticated.

Mr. RANDALL. There certainly are differences among the States. I think, to defend a lot of my regulatory colleagues and the association, that in many cases it is reflective of the individual markets in those States, in terms of the regulations that are imposed. Health care markets, as you well know, Mr. Chairman, are different among SMSAs, so I think that is certainly a major factor.

Chairman THOMAS. And what we did, to be fair, in terms of the final version of our legislation that we sent to the President, which he vetoed, was we required folk to go to the State first, and when there was a clear indication of a frustration or a failure to get what you thought you needed out of the State, then you could come to the Federal Government. So we really wound up with kind of a fallback arrangement. That, I think, showed an evolving thought process about whether or not the solvency standards are a distinction without a difference. I'm looking forward to the NAIC providing us with some of that real experience.

Mr. RANDALL. We look forward to providing data to you as well.

Chairman THOMAS. The sooner the better. Thank you.

Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

Mr. MacDonald, I think you're to be congratulated. I can't help but hope that you got a little bit of advice and support from my friends at the CWA, and I know you have worked with them to perfect your good health plans.

Mr. MACDONALD. You'll be happy to know that when I leave this hearing I'm going over to see them.

Mr. STARK. As I say, it is an indication of what can be done when people work together.

Mr. Randall, I, too, would like to see the State regulatory agencies have much more input into this, and I would be happy to turn it over to certain States. Now, we've got a problem in California, for instance, where the corporation commissioner is regulating HMOs. It makes little sense to me because I think as long as they've got 3 months of expenditures in the bank, that's about the extent to which they regulate them. It would make more sense, I think, for either a health department, an insurance department, or a combination of the two, to do it. I hope that NAIC can—as the delivery of health care changes—begin to say maybe not even all insurance commissioners have the capability of all the technical expertise and maybe it has to be a combination of medical expertise or other professions that can get together. It will get done more quickly if the States do it aggressively. Some States don't do it at all, won't sign up with your model plans, and at that time I think it's incumbent on us to provide a fallback position so that everybody can count on some regulation.

Ms. O'KANE, I have from time to time suggested that I'm uncomfortable with both your group and JCAHO insofar as providing any services to the Federal Government, where we don't pay for them and don't have the ability to set the standards under which they're provided. If you want to sell your services to GTE, that's between you guys, but—

Ms. O'KANE. We don't actually sell our service to GTE. GTE mandates the accreditation—

Mr. STARK. Whatever. But I'm just suggesting there are some problems and questions raised by NCQA providing services to the Federal Government.

I want to deal for 1 minute here with an HMO that operates in California that right now is pushing legislation in our fair State to restrict the State's power to investigate HMOs. The HMOs are being investigated for refusing to recommend certain vaccines to its members, where a spokesman for the State says that it's very clear in this case that Varifax and something else should be recommended. They are under a court order to inform hundreds of thousands of members, 850,000 members, that chicken pox shots are recommended. Again, they are actually under a court order because of discouraging doctors from vaccinating babies for chicken pox.

They owe the Feds, us, \$25 million for overbilling over a 3-year period. The Department of Corporations in California has reported that since January 1994, they have received 11,000 complaints in this particular HMO and its plan for senior citizens.

They also had to go to court to enforce a \$500,000 civil fine for the improper limitation of care to a young girl. Three subsidiaries of this managed care plan were fined \$70,000 in California for a variety of infractions. This is all pulled up by Lexis/Nexis at random. This is pretty easy to find now that we're on the Internet as well.

I might add, in the State of Oregon, this HMO was ordered to pay a civil penalty for denying claims without conducting a reasonable investigation, refusing to pay claims, even though the liability was clear, and failing to maintain proper records concerning proper

treatment to its policyholders in compliance with the Oregon insurance code.

Now, you mentioned your "hot line," which I called a few minutes ago—one of my staff did—to find out whether this HMO is accredited by you. We were told they can't give that information out over the phone. So, so much for your "hot line." We did find out, however, subsequently that the HMO has been accredited and its chief executive officer is a member of your board of directors.

Ms. O'KANE. He just came on our board of directors.

Mr. STARK. Now, that leads me to be very suspicious of whether we have the fox in the hen coop. I just don't believe the public can have much confidence in people who hold themselves out to regulate the people from whom they are soliciting the funds to do the regulating.

So I'm sorry we have to have companies like PacifiCare and people like Allan Hoops leading those companies—companies which are obviously not fit to be delivering care to the public. But then to have them on the boards of directors of companies that proposed to regulate, for me, absolutely disqualifies any reasonable and objective assessment.

I do think there is need for the public to be informed, but thus far, there is precious little indication—and they're not getting a lot better out of HCFA, I might add. But at least, short of Mr. Hoops staying in the Lincoln bedroom, which I guess I ought to check, there could be precious little around for the beneficiaries to have confidence in. You're not alone on this. The only thing I've heard today is you've got to go to work for GTE.

Do you have any openings, Mr. MacDonald? Or CALPERS, in the State of California, has done a pretty good job, and I can think of no conflicts of interest which exist on their board. There obviously are conflicts on your board, they're on JCAHO—

Ms. O'KANE. Would you like me to respond, because you've raised a number of points.

Mr. STARK. You can if you want. The facts are all there in the record.

Ms. O'KANE. I have a lot of other facts that I could raise, too, but if—

Mr. STARK. Is there anything wrong with those facts I just gave?

Ms. O'KANE. No, there is nothing wrong.

Mr. STARK. OK.

Ms. O'KANE. It's true that we have PacifiCare on our board. We have 6 managed care organization seats out of 20 seats. We do believe it's important to have representation from the industry we are accrediting.

On the issue of who pays for the reviews, it's a public good. If GTE were to pay for the accreditation, that would mean General Motors wouldn't have to pay, and that creates a problem. So there is a one-time payment, which is typical. Underwriters Laboratories, any other accreditation system in the country, works that way.

Chairman THOMAS. Does anyone want to respond to anything that was—I'm trolling here now. No one rises.

All right. I thank the panel very much.

I want to thank the last panel of the day, which consists of Karen Ignagni, who is with the American Association of Health

Plans. We have with us again Beatrice Braun, Dr. Braun, who is a member of the board of directors of the American Association of Retired Persons, and Dr. Daniel Johnson, who is president of the American Medical Association.

I would say to you that your written testimony, if you have any, will be made a part of the record, and you can apparently address me in any way you wish.

We will start with Ms. Ignagni.

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICAN ASSOCIATION OF HEALTH PLANS

Ms. IGNAGNI. Thank you, Mr. Chairman. On behalf of AAHP, the American Association of Health Plans, we are delighted to have been invited here and look forward to your questions, particularly in the area of quality and regulation.

I would say that, without a doubt, there have been major changes in the health care delivery system in a very short period of time, as you have observed in your opening remarks. As a result, our plans have gone, in a very short period of time, from being alternative health care providers to becoming the dominant delivery systems in their areas.

We think and hope the chart we have submitted with our testimony is helpful to you as you look at the current regulatory arena at both State, Federal, NAIC, NCQA, and so forth. As we look at it, what we think we can contribute is some serious attention, reaction, and hope to support this Subcommittee's effort to explore the range of issues before you.

I would like to highlight what is highlighted in our testimony on our recent initiative, which is Putting Patients First. To deal with the issue very directly, Mr. Chairman, we think that because of the major changes in the delivery system, a number of issues have been raised and need to be addressed very straightforwardly. We have endeavored to do that with our Putting Patients First initiative, which began approximately 1 year ago.

We began our first announcement of initiatives back in October, and then in December and in January, and most recently, our board of directors voted unanimously to move forward with a recommendation to our membership, that these proposals and these standards of practice become a mandatory part of our standards for membership within AAHP.

So we are delighted to participate in this process. We hope to draw the Subcommittee's attention to those endeavors.

We would also, by way of conclusion, suggest that the major transitions we have undergone in the health care delivery system have, in fact, brought affordable health care products to working families who heretofore didn't have them, made a system that was unaccountable accountable, and has allowed us to make great strides in the area of quality measurement.

Are we finished? Absolutely not. We, on behalf of the industry, are pleased to participate and support your efforts to explore what is in existence now in terms of the regulatory framework, what needs to be done in the future, and to separate out the issues that relate to quality versus issues that relate to stopping change.

Thank you.

[The prepared statement and attachments follow:]

**Statement of Karen Ignagni, President and Chief Executive Officer,
American Association of Health Plans**

I. INTRODUCTION

Mr. Chairman and members of the Subcommittee, I am Karen Ignagni, President and CEO of the American Association of Health Plans. AAHP represents approximately 1,000 health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other network-based health plans throughout the United States. Together AAHP member plans provide care for more than 140 million Americans.

I appreciate the opportunity to testify today about major initiatives in both the public and private sectors to promote quality and accountability in network-based health plans. The scope and extent of activities being undertaken in HMOs, PPOs, and similar plans in both of these areas—quality and accountability—are unprecedented. A decade ago, when the fee-for-service system represented the dominant form of health care delivery in the United States, there were few, if any, tools available to purchasers for measuring physicians' and health plans' performance in providing quality care. Now, as a result of the leadership role that network-based plans are playing, increasing numbers of consumers and employers have access to high-quality information about plan performance, thus enhancing their ability to make informed choices about coverage options.

Certainly, health plan activities are not taking place in a vacuum. Health plans are listening and actively responding to the needs and concerns identified by various stakeholders, in order to maintain and continuously improve the health care delivery process for all Americans. My comments today focus on four specific areas:

- Regulatory initiatives through which the Health Care Financing Administration (HCFA) and AAHP member plans are working to address the needs of Medicare beneficiaries;
- Initiatives undertaken by coalitions of purchasers, health plans, and consumer organizations to measure health plan performance and to facilitate a process of continuous quality improvement;
- Individual health plan efforts to promote health care quality and responsiveness to patient needs; and
- AAHP's Philosophy of Care and Putting Patients First, a national initiative to respond to changing needs and concerns of patients and physicians.

II. PUBLIC-SECTOR INITIATIVES TO PROMOTE QUALITY AND ACCOUNTABILITY

HCFA Regulation

The Medicare program's regulatory requirements for HMOs typify the scope and direction of federal regulatory oversight of network-based health plans. The rapid pace of HMO enrollment among senior citizens has heightened the importance of HCFA's oversight activities. From 1991 to 1996, the number of Medicare beneficiaries enrolled in health plans more than doubled, from 2.2 million to 4.9 million. Whereas just five years ago, 6.4% of the Medicare population was enrolled in health plans, today nearly 13% of Medicare beneficiaries are health plan members. According to HCFA, approximately 1 million Medicare beneficiaries are joining HMOs and competitive medical plans (CMPs) each year. As of January 1997, 284 HMOs and CMPs had Medicare contracts with HCFA, a 31% increase over the number of Medicare contracts in place during January 1996. In light of this phenomenal and unprecedented growth, HCFA initiatives will affect a substantial portion of the health care market.

HCFA has established comprehensive regulatory standards governing HMOs' participation in the Medicare program. Currently, all Medicare health plans meet the statutory requirements established for HMOs and CMPs in their states of operation. In addition, HMOs seeking to become Medicare contractors must complete a detailed application documenting their qualifications in areas such as the availability of network providers throughout the proposed service area and adequacy of financial resources. When health plans seek to expand their service area, they must file an additional application with HCFA.

Beyond establishing standards for participation, HCFA monitors health plans' performance on an ongoing basis by conducting regular site visits. These visits examine all aspects of health plan operations, including: accessibility of services; operation of the quality assurance program; marketing activities; and enrollment procedures. Besides conducting general oversight, HCFA reviews specific health plan ac-

tivities in key areas. For example, Medicare health plans must submit all proposed marketing materials to HCFA for approval, and plans must file annual benefit and rate proposals for HCFA's review and approval.

AAHP and our member plans recognize HCFA's critical role and responsibilities. We have been working closely with HCFA officials to promote strategies that meet their regulatory objectives. We believe that effective, ongoing communication between the Agency and Medicare contractors results in constructive interaction that ultimately provides tangible benefits to Medicare beneficiaries. Today I will highlight four examples of ongoing efforts being undertaken by HCFA with active involvement of the health plan community: (1) development of national marketing guidelines for health plans participating in the Medicare program; (2) implementation of regulations for physician incentive plans (PIPs); (3) an initiative to promote beneficiary understanding of and access to health plan grievance and appeals procedures; and (4) dissemination of information about health plan performance in key areas.

Marketing Guidelines: AAHP and health plan representatives have worked closely with HCFA and its regional offices on HCFA's development of national marketing guidelines for Medicare contractors. These guidelines are intended to support the efforts of health plans, HCFA, and consumer groups to ensure that information provided to beneficiaries is easily understood and contains the information necessary for making well-informed choices. By providing health plans with more detailed guidance and by promoting more consistent reviews by HCFA regional offices across the country, the guidelines are designed to help health plans and HCFA staff strengthen the review and approval process governing health plan marketing. The marketing guidelines were circulated broadly to consumers, health plans, and other organizations for comment. When completed, they will help ensure that Medicare beneficiaries across the country have useful, accurate information about their coverage options.

Physician Incentive Regulations: Shortly after HCFA published final regulations implementing statutory requirements for Medicare and Medicaid contractors' physician incentive plans, a working group of AAHP staff and health plan representatives began identifying practical issues that needed to be resolved so that plans could structure their compliance programs correctly. As the Agency began drafting implementation guidelines, AAHP offered technical assistance from the work group. HCFA accepted this offer, and the result was development of a uniform reporting protocol that HCFA determined would provide the information necessary for performing effective oversight and enforcement activities.

Physician incentive arrangements are highly varied. To account for these variations, HCFA and AAHP plan representatives worked for many hours to draft a protocol that would apply to the full spectrum of incentive arrangements while promoting consistency in the execution of health plans' and providers' reporting responsibilities. The protocol included guidance on interpreting the regulations, as well as reporting forms and step-by-step instructions for completing the forms. In addition, HCFA has issued a question-and-answer document to provide additional background information.

AAHP member plans have worked intensively to establish compliance programs that meet HCFA standards. HCFA and AAHP are continuing our dialogue as these efforts continue, and we believe that ongoing communication will ensure that as questions are raised or problems are identified, these issues can be addressed. Undoubtedly, the regulatory framework will evolve as health plans, physicians, and the Agency gain experience in the implementation process.

Grievance and Appeal Procedures: Currently HCFA is developing regulations to address Medicare beneficiaries' concerns about the accessibility and effectiveness of health plan grievance and appeals procedures, for example, by shortening the time-frame for completing these procedures. AAHP member plans place a high priority on ensuring that Medicare beneficiaries understand their rights and can exercise them. Accordingly, we have communicated with HCFA about the need to address all components of the appeals process in order to strengthen it. For example, we have recommended that non-network physicians who have delivered care related to a grievance or appeal should be required to provide the needed medical records on a timely basis and that if review by an administrative law judge is necessary, this review should occur without excessive delay.

Many senior citizens are enrolling in HMOs and other organized systems of care for the first time. We want seniors to be confident that if problems do arise, there are prompt and fair mechanisms for resolving any misunderstandings or disagreements. In October 1996, AAHP adopted a policy that explicitly affirms our member plans' commitment to accessible, fair, and timely grievance and appeals procedures for Medicare beneficiaries. After adopting this policy, we shared it with Secretary

Shalala and offered to work with the Department and with HCFA in ongoing efforts to improve existing regulatory requirements related to the rights of Medicare health plan members. Attached for the record is a copy of our letter to Secretary Shalala.

We believe that the direction HCFA is taking will be consistent with our interest in ensuring that beneficiaries understand when and how to exercise their rights and that all aspects of the grievance and appeals process function in a timely and responsive manner. We look forward to continued consultation with the Agency to facilitate an implementation process that addresses Medicare beneficiaries' needs without establishing unnecessarily burdensome procedural requirements.

Health Plan Performance—HEDIS Reporting: Beginning on June 30th of this year, HCFA will require Medicare health plans to report selected performance measures included in the Health Plan Employer Data and Information Set 3.0 (HEDIS 3.0). The purpose of this reporting is to ensure that the Agency has data that enhances contract oversight and that provides information which ultimately will help Medicare beneficiaries make more informed choices among health plans. We are pleased that HCFA plans to extend its regulatory efforts to include examination of fee-for-service Medicare providers' performance as well as examination of health plan performance. The health plan community participated in a HCFA meeting last September, during which consumers, health plans, and other organizations provided comments on the HEDIS 3.0 initiative and on the Agency's plans to require administration of a standardized patient satisfaction survey. We have continued our dialogue with HCFA to promote timely, efficient, and well thought-out implementation of these initiatives.

The HEDIS 3.0 measures were developed with input from employers, consumer and labor representatives, health plans, and quality experts. HEDIS 3.0 includes detailed information on health plan performance in the areas of quality, access to care, patient satisfaction, membership stability, use of resources, financial soundness, internal management systems, as well as measures specific to the health care needs of Medicare beneficiaries. We are pleased that HCFA has drawn upon the experience of HEDIS implementation in the private sector. Because HCFA's reporting requirements will be consistent with those established for health plans contracting with private purchasers, implementation of HEDIS 3.0 in the Medicare program has great potential to provide valuable information to Medicare beneficiaries while avoiding excessive and unnecessary administrative burdens for health plans.

Health Plan Performance—The Medicare Beneficiary Satisfaction Survey: In a related effort, HCFA will use a survey developed by the Agency for Health Care Policy and Research (AHCPR) to measure patient satisfaction in Medicare health plans. Based on the survey's results, HCFA will develop comparative reports for Medicare beneficiaries about the health plans available in their geographic areas. AAHP and our member plans hope to work with HCFA and AHCPR to offer technical assistance as the agency analyzes survey results and develops comparative information for Medicare beneficiaries.

In short, AAHP is committed to working closely with HCFA to enhance the effectiveness of Agency policies and to promote streamlining of the regulatory compliance process. We believe these objectives are compatible. The regulatory initiatives I have just discussed demonstrate that ongoing, open communication between HCFA and health plan representatives provides an effective means for achieving these objectives in a manner that ultimately benefits Medicare beneficiaries.

Other Government Requirements

In carrying out its responsibilities for the Medicare program, HCFA plays a key role in setting health plan standards. However, it is not the only entity involved in establishing these standards. In contrast to the fee-for-service sector, HMOs and other integrated delivery systems are highly regulated through a number of federal and state government programs. These programs include federal qualification under The Federal HMO Act, state licensure, and the Federal Employees Health Benefits Program (FEHBP). The attached chart summarizes government standards in the key areas of quality, access, and physician credentialing procedures. Additional federal and state requirements address areas such as consumer information, health plan solvency, and grievance systems.

III. JOINT INITIATIVES UNDERTAKEN BY PRIVATE PURCHASERS, CONSUMER GROUPS, AND HEALTH PLANS

Requirements of Medicare and other federal programs, as well as standards established through state law and regulation, provide the framework for health plan operations. But these basic rules are only the beginning. Health plans are actively par-

ticipating in many private-sector initiatives designed to promote health care quality and accountability.

As more and more Americans choose HMOs and other network-based plans, consumers, employers, and health plans have played a pivotal role in developing benchmarks and other methods to hold health plans and physicians accountable for the quality of care they provide. My comments today focus on two important private-sector systems to facilitate health plan accountability: (1) the private accreditation process; and (2) reporting of health plan performance data.

Private Accreditation

Many employers—particularly large companies—require all health plans serving their employees to be accredited by private organizations, usually the National Committee for Quality Assurance (NCQA), but also the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), the Utilization Review Accreditation Commission (URAC), or the Accreditation Association for Ambulatory Health Care (AAAHC). NCQA, the largest health plan accreditation organization, characterizes its accreditation requirements as a “gold standard” to which all health plans can aspire but which not all plans can meet. Accreditation standards are rigorous and constantly evolving, thus challenging health plans to continuously improve quality and consumer satisfaction.

To gain accreditation, health plans must meet extensive requirements in the areas of quality improvement, physician credentialing, recognition of member rights and responsibilities, preventive health services, utilization management, and maintenance of clinical records. For example, NCQA requires plans to operate a comprehensive quality improvement program to monitor and evaluate the quality and appropriateness of clinical care and member services. Monitoring and evaluation programs must address high-volume and high-risk services, as well as treatment for acute and chronic conditions.

As of January 31, 1997, 227 HMOs had received NCQA accreditation. A 1996 study of nearly 400 U.S. employers conducted by Watson Wyatt Worldwide and the Washington Business Group on Health found that 60% of employers with 10,000 or more employees consider a health plan's NCQA accreditation status when making purchasing decisions. These trends provide benefits that extend beyond the large employer market. Small businesses and individuals choosing a health plan that has obtained NCQA accreditation can be assured that their plan represents a “gold standard” among the coverage options available.

Health plans, employers, and consumers recognize that it is not sufficient to simply compile statistics and file reports. To gain NCQA accreditation, for example, health plans must demonstrate an understanding of the data they gather, and they must implement plans to make any necessary improvements. For example, if a health plan's childhood immunization rates are low, it must have an action plan to increase those rates to appropriate levels.

Reporting of Performance Data

HEDIS: As stated in my earlier discussion of HCFA's use of HEDIS 3.0 to conduct quality oversight in the Medicare program, HCFA has followed the private sector's lead in creating health plan performance measures. In the early 1990s, private employers, consumer and labor representatives, health plans, and quality experts began developing HEDIS measures, and health plans began using an earlier version of HEDIS in 1993. In the past several years, HEDIS measures have been refined, and to date, they have been used by more than 330 health plans throughout the country. The 1996 Watson Wyatt/Washington Business Group on Health survey found that 54% of employers with 10,000 or more employees now consider HEDIS data when making purchasing decisions.

IV. INDIVIDUAL HEALTH PLAN INITIATIVES TO RESPOND TO CONSUMER NEEDS AND CONCERNs

While increasing health plan enrollment has provided the impetus for developing external public- and private-sector initiatives to promote quality and accountability, it is important to note that internal health plan programs to promote quality and customer satisfaction have been a hallmark of HMOs and similar health plans since their inception. Health plans have implemented a wide variety of programs to support their quality improvement goals and to accommodate consumer needs and preferences. I will focus on just a few of these today: (1) customer satisfaction surveys; (2) point-of-service products; and (3) programs to streamline the process of coordinating patient care.

Consumer Satisfaction Surveys

As part of their ongoing quality improvement initiatives, virtually all health plans conduct patient satisfaction surveys. Based on findings from these surveys, health plans modify their operations where appropriate. Operational modifications have included changes in member orientation programs, providers' business hours, and health education classes.

Point-of-Service Products

In response to market demand, the vast majority of HMOs voluntarily offer a point-of-service (POS) product, in which members can receive coverage for care provided by physicians not affiliated with the HMO in exchange for assuming a larger share of the cost. The proportion of HMOs offering POS products grew from 23% in 1988 to an estimated 81% in 1996.

Programs to Streamline the Coordination of Care

To accommodate consumer preferences, health plans are developing new means of streamlining the coordination of care provided by primary care physicians and specialists. For example:

- One of our member plans is computerizing the referral process using a system designed by the health plan's physicians and medical academicians. Through this system, primary care physicians will be able to obtain immediate approval for referrals by typing "yes/no" answers to a series of questions about the patient's condition.
- Another plan has established a "virtual M.D." system that allows members to access their primary care physician on-line and obtain a referral over the Internet.
- A third approach adopted by one of our member plans is the use of electronic terminals that allow physicians to obtain on-line, real-time referral authorizations to specialists with the swipe of a member's I.D. card. The system currently is in use by over 500,000 health plan members, and the plan expects that more than half of its membership nationwide will begin using the system by the end of 1997.

V. AAHP'S NATIONAL INITIATIVE TO RESPOND TO PATIENT AND PHYSICIAN NEEDS

By participating in federal regulatory initiatives and in private-sector programs to promote health care quality and accountability, health plans have demonstrated their commitment to meeting consumers' needs, as well as the needs of public- and private-sector purchasers. To highlight this long-standing commitment and demonstrate health plans' ongoing responsiveness to patients' interests, AAHP and our member plans have embarked on an important initiative called Putting Patients First. The Putting Patients First initiative advocates a set of specific health plan policies that promote high-quality care in a manner that meets the needs of individual patients. The foundation for this initiative is AAHP's Philosophy of Care, a set of core principles that all of our member plans support. The following sections provide additional detail on AAHP's Philosophy of Care and Putting Patients First.

Philosophy of Care

In February 1996, AAHP adopted a Philosophy of Care, which represents fundamental principles that guide the health care delivery process in network-based health plans throughout the country. A full text of the Philosophy is attached, and I will highlight a few of its core principles for you now.

Shared Decisionmaking: Health care decisions should be the shared responsibility of patients, their families, and health professionals. AAHP member plans encourage doctors to share information with patients on their health status, medical conditions, and all available treatment options.

Choice: Patients should have a choice of physicians who meet high standards of professional training and experience. Informed choice and freedom to change doctors are essential to build active partnerships between doctors and patients.

Information: Consumers have a right to information about health plans and how they work.

Appropriate Care: Patients should have the right care, at the right time, in the right setting. This includes comprehensive care for acute and chronic illness—as well as preventive care—in the hospital, at the doctor's office, or at home.

The Philosophy of Care represents more than words on a page. Accordingly, in response to identified patient needs, AAHP adopted an affirmative policy on mastectomy care, and we are working with our member plans to implement Putting Patients First. The following sections provide an overview of these initiatives.

AAHP's Policy on Mastectomy Care

In late 1996, stories reported by several prominent news organizations suggested that breast cancer patients were being denied overnight hospital stays following a mastectomy, even when a woman's physician believed that hospitalization was the best option for her. Standard practice in AAHP member plans is for women and their doctors to jointly make the decision about the best care following a mastectomy, including whether to stay in the hospital or to return more quickly to their homes and families.

Interestingly, research has found that the type of health coverage a woman has does not determine whether she will undergo mastectomy on an inpatient or an outpatient basis. A national study of privately insured women conducted by the MEDSTAT Group for AAHP found that women in HMOs were no more likely than women in fee-for-service plans to undergo an outpatient mastectomy. In New York State, the majority of outpatient mastectomies in 1995 were provided to women in the Medicare fee-for-service program. Of the 74 outpatient mastectomies provided to Medicare beneficiaries in New York, 72 were for women with Medicare fee-for-service coverage, and just two were for Medicare HMO members. Doctors and patients—not health plans—are deciding whether care should be provided in an inpatient or an outpatient setting.

However, because of the importance and sensitivity of the mastectomy stay issue and to reassure patients facing this difficult surgery, in November 1996, AAHP's Board of Directors formally adopted a policy that states the following: "The decision about whether outpatient or inpatient care best meets the needs of a woman undergoing removal of a breast should be made by the woman's physician after consultation with the patient. Health plans do not and should not require outpatient care for removal of a breast. As a matter of practice, physicians should make all medical treatment decisions based on the best available scientific information and the unique characteristics of each patient."

AAHP's policy statement on mastectomy care represents an important first step in a broader strategy to put the *Philosophy of Care* into practice. The next step in this process is implementation of AAHP's Putting Patients First initiative.

Putting Patients First

AAHP's Putting Patients First initiative is an ongoing, comprehensive program to let patients and doctors know what they can expect from their health plans in a number of key areas. A task force of AAHP's Board of Directors task force is charged with identifying and highlighting specific health plan policies and programs that can respond effectively to patients' and physicians' needs. The following are the components of the initiative that have been announced to date.

Information for Patients and Physicians: In December 1996, AAHP announced its policy on patient information. This portion of the initiative calls attention to AAHP member plans' commitment to ensuring that patients can obtain, upon request, clear information about how their health plan's physicians are paid; how the health plan makes decisions about medical necessity and the basis for specific decisions; whether specific prescription drugs are included in the health plan's formulary; and how the plan decides whether a treatment or procedure is considered "experimental." The policy also states that health plans should inform members about the plan's structure and provider network; benefits covered and excluded, including out-of-area and emergency coverage; and cost-sharing requirements.

In announcing this portion of Putting Patients First, AAHP reiterated that health plans encourage full and open communication between patients and physicians about patient care. AAHP policy states that health plans will not prohibit physicians from communicating with patients about medical care, medically appropriate treatment options (whether or not these treatments are covered by the plan), or from making factual and nonproprietary statements about the health plan. Consistent with ethical practice, health plans should be permitted to prohibit their affiliated physicians from soliciting patients to join a different plan.

In January 1997, AAHP announced two more elements of Putting Patients First: AAHP's policies regarding emergency care and patient appeals of coverage decisions.

Emergency Care: AAHP's emergency care policy is designed to facilitate a swift, medically appropriate, and coordinated approach to treating patients facing a medical emergency. This policy states AAHP's position that health plans should cover emergency department screening and, if necessary, stabilization services for conditions that reasonably appear to constitute an emergency based on a patient's presenting symptoms. Emergency conditions can be defined as those that arise suddenly and require immediate treatment to avoid jeopardizing a patient's life or health. To promote optimal, coordinated care, the emergency department should

contact the patient's primary care physician as soon as possible. The purpose of this policy statement is to ensure that patients know when common sense tells them they need immediate treatment to stabilize a medical emergency, their health plan will cover the treatment.

Appeals of Coverage Decisions: As noted in my earlier discussion of Medicare appeal procedures, health plans place a high priority on informing members about procedures for appealing coverage decisions. To increase consumer understanding of this issue and to reiterate AAHP member plans' commitment to promoting fairness, timeliness, and clarity in the appeals process, AAHP's policy on patient appeals of coverage decisions states that health plans should provide timely notice to patients when a plan determines that a particular treatment or procedure will not be covered or when there is disagreement between the patient and physician about the course of treatment. This notice should include an easily understood description of patients' appeal rights and the time-frame for appeals. In addition, the policy calls for health plans to establish an expedited appeals process when the standard time-frame health plans have established for appealing coverage decisions could seriously jeopardize patients' life or health.

Compliance: On February 24, 1997, AAHP's Board of Directors approved a process for ensuring compliance with Putting Patients First. Health plans joining AAHP or renewing membership will be required to uphold the association's patient-centered policies. Procedures to be implemented as part of the new compliance process are designed to support and strengthen health plan efforts to uphold these patient-centered policies, and they allow the association to exclude health plans that do not.

Next Steps in Putting Patients First: AAHP will continue to announce specific elements of Putting Patients First throughout this year and will work with member plans to demonstrate their active support for these policies. In addition, AAHP is engaged in ongoing dialogue with representatives of consumer, physician, and employer organizations to facilitate widespread understanding of the initiative and of its value to consumers.

VI. CONCLUSION: THE NEED TO PROMOTE FLEXIBILITY WHILE UPHOLDING HIGH STANDARDS

AAHP and our member plans believe that we represent a unique community that is meeting high standards of patient care. Clearly, the federal government and state policymakers play a critical role in establishing a basic framework for operation and providing oversight not only of health plans, but of all health care organizations, physicians, and other health care providers. Beyond complying with federal and state standards, health plans are taking the lead in promoting health care quality, access, and affordability by implementing initiatives such as Putting Patients First, by establishing additional internal programs tailored to their members' needs, and by meeting rigorous standards for private-sector accreditation.

Public policy should be flexible enough that health plans can continue providing effective leadership in these areas. While policymakers have good intentions when they develop proposals to mandate particular clinical practices, it is important to realize that many of these proposals, if implemented, could have unintended consequences. For example, a number of clinical mandates currently under consideration would codify a particular approach to disease management and treatment. Medical treatment standards are constantly evolving, thanks to our nation's unparalleled capabilities in medical innovation. Public policy should foster rather than hinder these important developments and technological advancements.

By committing ourselves to Putting Patients First and by engaging in the other activities I have discussed, AAHP and our member plans have demonstrated that they are listening and responding to consumers' and physicians' needs. We committed to upholding high standards of patient care. AAHP and our member plans are prepared to be held accountable for our actions, and we believe that all health care organizations and providers should likewise be held accountable. We welcome the Subcommittee's interest in these issues, and we thank you for providing the opportunity to testify today.

AMERICAN ASSOCIATION OF
HEALTH PLANS
October 30, 1996

The Honorable Donna Shalala, Ph.D.
 Secretary for Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 615-F
Washington, D.C. 20201

Dear Dr. Shalala:

Recently, a great deal of attention has been focused on grievances and appeals rules for health plans contracting with the Medicare program. Bruce Vladeck, Administrator, Health Care Financing Administration, and Bruce Fried, Director, Office of Managed Care, called attention to the responsibilities of HCFA and the health plans in their speeches at the September Medicare conference of the American Association of Health Plans (AAHP).

AAHP member organizations participate in the Medicare program. They are strongly committed to ensuring that the beneficiaries they serve are familiar with and know how to exercise all of their Medicare rights. Recent inquiries from beneficiary groups have prompted development of the attached statement of principle. This statement emphasizes the practices AAHP member plans believe are essential to providing beneficiaries with the information and procedures necessary for them to pursue their rights. It also highlights recommendations that we believe are critical to strengthening beneficiary access to appeal rights by improving and complementing existing HCFA requirements in the areas of:

- improved beneficiary information and education
- improved health plan accountability
- simplification and improvement of all parts of the Medicare appeals process

We would like to work collaboratively with the Department and others on these priority areas to enhance the ability of Medicare beneficiaries to exercise their rights. In addition, AAHP is committed to continuing to participate in HCFA's effort to improve the existing regulatory requirements for health plans. We pledge our full cooperation in working with the Agency to implement Medicare rules designed to ensure that beneficiaries can take full advantage of their rights.

Medicare beneficiaries are choosing to enroll in health plans in growing numbers. AAHP's members are dedicated to providing them with affordable, quality health care and to ensuring that if problems arise, they can pursue the remedies guaranteed them by the Medicare program. We look forward to working with you on these important initiatives.

Sincerely,

KAREN IGNAGNI
President and CEO

Enclosure

Medicare Appeal Rights: Putting Patients First

A COMMITMENT TO BENEFICIARIES

The American Association of Health Plans (AAHP), representing more than 1000 HMOs, PPOs, and similar health plans, is committed to a philosophy of care that puts patients first by providing the right care, at the right time, in the right setting. Our member plans believe that a fundamental cornerstone of this philosophy is giving Medicare beneficiaries the information and the support they need to make them full partners in the effort to promote health and to treat illness and injuries effectively.

To realize this commitment, our member plans recognize that accessible, fair, and timely grievance and appeals procedures must be in place and understood by both enrollees and all providers and health plan personnel. Beneficiaries must have the information and assistance they need to pursue their rights under the Medicare program in a timely and supportive manner. In short, health plans must be account-

able for making these grievance and appeals procedures work and for educating beneficiaries and plan providers about their rights and responsibilities. Non-plan providers must be accountable for supplying information necessary to resolution of appeals. The Health Care Financing Administration (HCFA) must ensure timely resolution of appeals that rise beyond the plan level.

Our member plans also recognize that they have a special challenge to help their Medicare members understand how a coordinated system of care operates. Increasing numbers of Medicare beneficiaries are enrolling in HMOs and other organized systems of care for the first time. These new enrollees need a thorough orientation to health plan procedures including information about their appeal rights. Health plans must act within time frames that protect the health of the patient.

Our member plans are committed to working with beneficiary advocacy groups and HCFA to pursue the common goal of enhancing the operation of grievance and appeals mechanisms. AAHP and its member plans believe there are a number of key elements of grievance and appeals processes that must be in place if beneficiaries are to realize their rights to full participation in care decisions. We also believe that new initiatives can be undertaken—working with beneficiary advocates and HCFA—that will strengthen beneficiary rights and the performance of health plans and providers. Like health plans, we believe that HCFA, participating providers and others responsible for carrying out the fee-for-service Medicare program must also increase their efforts to ensure that beneficiaries are knowledgeable about and can fully exercise their rights and receive prompt resolution of any problems.

The following statement reflects the commitment of our member plans to the promotion of beneficiary rights and to their accountability for the appropriate exercise of those rights.

KEY ELEMENTS OF PLAN RESPONSIBILITIES

- **Beneficiary Information/Education:** Since beneficiaries are full partners in the maintenance of health and the treatment of illness, they must have the information necessary to understand what their rights are, how a health plan functions, and how they can pursue their rights. We believe this educational process begins with the first contact beneficiaries have through marketing and other informational materials and continues with more detailed information at the time of enrollment and periodically throughout the entire period of their enrollment.

Our plans provide information and education in written materials and frequently in orientation briefings. They also provide telephone access to member services representatives who can assist beneficiaries in learning about and pursuing their rights. Key to this effort is assuring that the information is user-friendly, and, with respect to appeals rights, that beneficiaries understand the plan's obligation to provide timely written notices of the reasons for any adverse coverage or service decisions and how to pursue an appeal. Responses to telephone inquiries and written materials must be culturally and linguistically appropriate to the beneficiaries served by the plan. Written notices should be required whenever health plans make adverse coverage determinations or the beneficiary disagrees with provider treatment recommendations. Further, beneficiaries must be informed about the time frames within which plan-level appeals will be resolved and must be referred to member service personnel or others whose responsibility it is to assist the beneficiary with an appeal.

If there is a disagreement about whether a service should be provided, and the generally applicable time frames for appeals could seriously jeopardize the life or health of the beneficiary, our member plans believe that beneficiaries must have access to an expedited appeals process for these time sensitive situations—one that renders decisions as rapidly as the condition of the beneficiary warrants. While health plans must render timely decisions in these circumstances, the health and welfare of beneficiaries requires that action at all levels of the appeals process take place quickly in such cases. This means that appeals beyond the health plan must also be expedited by the Center for Health Dispute Resolution (CHDR) and Administrative Law Judges, if they progress to that level.

- **Provider Information/Education:** Participating Medicare health plans include a variety of delivery system models—models in which the relationship between the plan and its providers varies. Thus, it is critical to educate all providers about beneficiary rights and the procedures for exercising those rights. This process begins at the time the provider joins the plan, and continues periodically throughout the relationship. Our plans are committed to fostering free and full communications between physicians and their patients about treatment options. They are committed to working with their providers to ensure they understand the beneficiary's rights, the obligation of the plan to provide written notices of adverse coverage decisions,

and the obligation of the provider to inform beneficiaries of their appeal rights, including a referral to the appropriate plan personnel for assistance with appeals, when they disagree with a treatment decision.

In this educational process, we believe it is essential that providers have information that clearly distinguishes when beneficiaries may appeal a decision beyond the plan, and that emphasizes the time-sensitive nature of appeals regarding pre-service denials and discharges from institutional settings. Providers must also understand their obligation to provide appropriate documentation promptly when required for the appeals process. Where pre-service denials occur or where there is disagreement about treatment recommendations, providers have an obligation to beneficiaries to inform them about their right to an expedited consideration when it is required because of their condition. Non-plan providers who have entered into Medicare participation agreements should be educated by HCFA about their responsibility to supply complete, timely information needed for health plans to process Medicare appeals.

- Health Plan Accountability: AAHP and its member plans recognize that—although they must often depend upon providers to be their “eyes and ears” with beneficiaries—the responsibility for protecting beneficiary rights ultimately rests with them. Underlying our philosophy of care is the recognition that honoring patient’s rights is essential to the kind of partnership that we seek to forge between the health plan and its enrollees.

Our health plans are committed to broad-based and continuing educational efforts for our members and providers. They will continue to ensure that the necessary resources are dedicated to supporting the educational process and to maintaining a responsive appeals process. Collaboration with beneficiary advocacy organizations and others to find the most effective ways of communicating information and for operating appeals procedures must be a continuing priority.

Our member plans also recognize their responsibility to monitor and improve the performance of providers that contract with the plan in meeting their obligations to beneficiaries. We believe that systems for monitoring compliance and for initiating special efforts where there is a pattern of problems or complaints need to be in place. We are also working to ensure that voluntary accreditation standards place proper weight on performance measures related to these obligations, providing another mechanism to hold plans accountable.

FUTURE INITIATIVES

While these are important steps, we believe that even more progress can be made through a cooperative effort involving health plans, beneficiary advocacy groups and HCFA. To that end, we have identified a number of initiatives that we believe should be undertaken:

- Improved Communication: Some of the current Medicare descriptions of beneficiary rights and appeals procedures could be made more patient-friendly. In some instances the language included in marketing materials or in plan determination notices—sometimes due to regulatory requirements—may cause more confusion than clarity. On behalf of our member plans, we would like to work with the agency, advocacy groups, and others to develop simple and complete explanations of plan and provider procedures and the rights of patients to participate in and appeal treatment decisions, as well as new strategies for beneficiary education. Such an effort would make a valuable contribution to helping both plans and beneficiaries meet their responsibilities and protect their rights.

- Improving Plan Accountability: AAHP supports enhanced efforts by health plans to be fully accountable for the performance of their participating providers in carrying out plan responsibilities under the Medicare program. This may include, among other things, knowledge about what actions providers may be taking, whether they make appropriate referrals to member service representatives, whether they fully comply with Medicare and plan coverage policy, utilization review criteria, and quality assurance standards, and whether they communicate information about the opportunity for beneficiary appeals.

- Simplification and Improvement of the Process: AAHP believes that the process of appeals could be simplified and improved by ensuring that all providers rendering care to Medicare beneficiaries contribute to timely resolution of the appeals through prompt submission of documentation. Appeals are sometimes unduly delayed because providers not associated with the health plan do not respond to information requests in a timely and complete manner. We need to find a way to protect beneficiaries from delays of this sort.

We also believe that all levels of the appeals process, including health plans, the Center for Dispute Resolution and administrative law judge need to be subject to

the same standard of timeliness. These review processes should include an opportunity for expedited appeals when the medical condition of the beneficiary warrants.

Finally, we believe the appeals process would be more responsive to beneficiary interests if, during the pendency of an appeal of a post-service or procedure denial, providers should be precluded from seeking payment from the beneficiary by referring claims to credit or collection services. Such actions have been the cause of unnecessary and inappropriate adverse credit references.

HMO Quality and Access Standards: Federal Standards, State Guidelines, and Private Accreditation Requirements

The following chart summarizes HMO quality and access standards established by federal law, federal programs acting as purchasers for specific populations, model state law, and a national private accreditation agency. Standards summarized include those applicable to: federally qualified HMOs; HMOs participating in Medicare, Medicaid, and the Federal Employees Health Benefits Program (FEHBP); HMOs in states adopting the National Association of Insurance Commissioners (NAIC) Model HMO Act or similar legislation; and HMOs accredited by the National Committee for Quality Assurance (NCQA). This chart does not include all types of standards applied to HMOs, for example, standards related to health plan solvency or to grievances and appeals.

Currently there are an estimated 630 HMOs nationwide. All of these organizations must comply with the HMO laws enacted in their states of operation. Twenty-nine states have enacted HMO laws that are identical or substantially similar to the NAIC Model HMO Act. An additional 21 states have enacted legislation to regulate HMOs that does not follow the NAIC model. Of the 630 HMOs in operation, the following participate in federal programs and/or have received NCQA accreditation and thus are subject to additional standards:

- 278 HMOs, accounting for 66% of total HMO enrollment, were federally qualified as of January 1996 and thus are subject to Federal HMO Act requirements.
 - As of January 1997, 284 HMOs were participating in the Medicare program.
 - 349 HMOs and 89 other prepaid health plans were participating in the Medicaid program as of June 1996.
 - 360 HMOs are participating in the Federal Employees Health Benefits program in 1997.
 - As of January 31, 1997, 227 HMOs had received NCQA accreditation.
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| Standard | Federal HMO Act | Medicare ¹ | Medicaid | FEHBP | NAIC Model HMO Act | NCQA Accreditation Standards |
|------------------------|---|--|---|---|---|---|
| Quality Assurance (QA) | To be federally qualified, HMOs must have: <ul style="list-style-type: none"> • QA program with emphasis on health outcomes (42 USC 300e(c)(6)) • Review of health care delivery process by physicians or other health professionals (42 USC 300e(c)(6)) • Systematic data collection; data interpretation; implementation of changes as needed (42 CFR 417.106) • Written procedures for remedial action deemed appropriate by the health plan to address QA issues (42 CFR 417.106) | To participate in the Medicare program, HMOs must have: <ul style="list-style-type: none"> • Ongoing QA program with emphasis on health outcomes • Review of health care delivery process by physicians or other health professionals (42 USC 300e(c)(6)) • External quality review by a peer review organization (PRO) (42 USC 1395(m)(7)(A)) • Systematic data collection; data interpretation; implementation of changes as needed (42 CFR 417.106) • Written procedures for remedial action deemed appropriate by the health plan to address QA issues (42 CFR 417.106) | Federal standards include: <ul style="list-style-type: none"> • Internal QA systems with review by appropriate health professionals, systematic data collection and analysis, and provisions for making changes as needed (42 CFR 434.34) • QA systems required under HCFA Terms & Conditions for approving Section 1115 waivers • Inspections by independent reviewer to determine that Medicaid health plans meet professionally recognized health care standards (42 USC 1396b(m)(6)(B)(iv)) • HCFA strongly encourages states to collect HEDIS 3.0 performance measures (HCFA Operational Policy Letter #47, issued December 1996) • Independent administration of a Medicare beneficiary satisfaction survey (HCFA Operational Policy Letter #47) • Establishment of written procedures for remedial action deemed appropriate by the health plan to address QA issues (42 CFR 417.418 and 42 CFR 417.106) | To participate in the FEHBP program, HMOs must use the following QA strategies: <ul style="list-style-type: none"> • Operation of QA program with specified procedures to address, at least, service quality and responsiveness to member inquiries and requests (§ 1.9 (a)(1–4) of 1997 Standard Contract) • Data collection and development of statistical reports on condition-specific patient outcomes (§ 1.9 (a)(8) of 1997 Standard Contract) • Use of a statistically valid sampling technique to measure claims against QA and fraud & abuse prevention standards • State Medicaid programs may establish additional quality standards, as long as they are not inconsistent with federal standards. | Ongoing QA program to monitor and evaluate health services (§ 7B of Model Act) <ul style="list-style-type: none"> • Procedures to ensure health care delivery under reasonable quality standards, consistent with recognition of medical practice standards (§ 7A of Model Act) • Written goals and objectives for QA program that emphasize improved health status (§ 7B(1) of Model Act) • Ongoing, focused activities to evaluate health care services (§ 7B(2) (e,f) of Model Act) • Written plans for taking corrective action as appropriate (§ 7B(5) of Model Act) | Organizational arrangements for quality improvement program (QI 1.0 of 1996 NCQA Standards for Accreditation) <ul style="list-style-type: none"> • Committee for quality improvement oversight and implementation, with active participation from providers (QI 1.5, 1.7) • Annual quality improvement work plan (QI 1.10) <ul style="list-style-type: none"> • Systematic monitoring and evaluation of health care quality and appropriateness (QI 5.0) • Identification of important areas for improvement and establishment of meaningful priorities (QI 6.0) <ul style="list-style-type: none"> • Use of quality improvement information in credentialing, re-contracting and/or annual performance evaluations (QI 3.1) |

| Standard | Federal HMO Act | Medicare ¹ | Medicaid | FEHBP | NAIC Model HMO Act | NQCA Accreditation Standards |
|---|---|--|---|--|--|--|
| Credentialing and Other Requirements for Affiliated Providers | <ul style="list-style-type: none"> No explicit statutory requirements Per HCFA guidance for federally qualified HMOs, the following activities demonstrate an organizational commitment to quality: <ul style="list-style-type: none"> —Recruitment of physicians who have demonstrated performance consistent with the HMO's established practice standards. —HMO evaluation of providers' patient complication rates, morbidity or mortality rates, extent to which providers engage in unproven medical practices; —Consideration of physician mal-practice payments, revocation, suspension of state license or DEA/BNND number, criminal convictions, curtailment or suspension of medical staff privileges; Medicare/Medicaid sanctions; censure by state or county medical associations —Examination of information from the National Practitioner Data Bank (NPDB). <p>—Recredentialing that incorporates NPDB information and physician performance data (HCFA manual for federally qualified HMOs § 4202.3(E)(1)(a))</p> | <ul style="list-style-type: none"> No explicit statutory provisions • Per attachment to HCFA guidance on HMO/provider contracts: <ul style="list-style-type: none"> —For services rendered to Medicare HMO members, providers must agree to review by the plan a QA and utilization management committee and/or staff. | <ul style="list-style-type: none"> Not referenced in federal standards • State Medicaid programs may establish their own credentialing standards. | <ul style="list-style-type: none"> Routine credential checks during initial hiring and re-credentialing process are required. • Credentialing procedures must include: verification of medical school graduation records, routine check with local and/or medical societies of boards; routine check of DHHS list of debarred providers; routine check of the National Practitioner Data Bank (§ 1.9 (a)(6) of 1997 Standard Contract) | <ul style="list-style-type: none"> • System for provider credentialing and peer review included in quality assurance program (§ 7B (2) (g)) | <ul style="list-style-type: none"> Verification of: practice license, clinical privileges in good standing at provider's primary admitting facility; valid DEA or CDS certificate as applicable; medical school graduation and completion of residency or board certification; work history; current, adequate mal-practice insurance; medical liability history (CR 5.0 of 1996 NQCA Standards for Accreditation) • Check of the National Practitioner Data Bank; check with the State Board of Medical Examiners or Department of Professional Regulation; check for sanctions by Medicare or Medicaid (CR 7.0, 13.0, 13.2) • Plan must review provider sites and record-keeping practices to ensure conformance with the health plan's standards (CR 8.1) • Recredentialing, reappointment, or recertification at least every two years (CR 10.0, 10.1) |

| | | |
|---|--|---|
| <p>Access</p> <ul style="list-style-type: none"> • Availability and accessibility of services in a reasonably prompt manner that ensures continuity of care, availability of medically necessary services 24 hours a day/ seven days a week (42 USC 300e(b)(4)) • Required HMO payment for out-of-network emergency services if services were medically necessary and immediately required due to an unforeseen illness, injury, or condition and it was not reasonable under the circumstances to obtain these services through the HMO (42 USC 300e(b)(4)) | <ul style="list-style-type: none"> • Same as Federal HMO Act standards for basic and emergency services (42 USC 1395mm(c)(4)) | <ul style="list-style-type: none"> • Federal requirements include: <ul style="list-style-type: none"> • Services available to Medicaid HMO members to same extent as available to beneficiaries in FFS Medicaid (42 USC 1396b(m)(1)(A)(ii)) • System established by the state Medicaid agency for periodic (at least once a year) medical audits to ensure that Medicaid health plans provide quality and accessible care (42 CFR 43.53) • Provision for payment of medically necessary, out-of-network emergency services either by HMO or state Medicaid program (42 USC 1396b(m)(2)(vii)) <ul style="list-style-type: none"> • State Medicaid programs may establish additional access standards, provided that they are not inconsistent with federal standards. |
| | | <ul style="list-style-type: none"> • Immediate care for emergency appointments (\$ 1.9(a)(7) of 1997 Standard Contract) • Availability of urgent appointments within 24 hours of authorized request (\$ 1.9(a)(7)(i) of 1997 Standard Contract) • Availability of routine appointments within one month, on average, of an authorized request (\$ 1.9(a)(7)(ii) of 1997 Standard Contract) • Average office waiting times (for members arriving on time for scheduled appointments) of 30 minutes (\$ 1.9(a)(7)(iii) of 1997 Standard Contract) <ul style="list-style-type: none"> • An average of 60% of written member inquiries responded to within 10 working days (\$ 1.9(a)(3)(i)(A) of 1997 Standard Contract) |

¹This chart highlights the major Medicare standards for quality assurance, provider qualifications, and access to care. For more extensive, detailed information, see the HMO/CMP Manual.

²The Secretary of the U.S. Department of Health and Human Services (HHS) is required to contract with a utilization and quality control PRO for an initial period of three years, renewable triennially, to review services provided through the Medicare program. Organizations eligible to contract as PROs must "show that they are either physician-sponsored or physician access organizations." A physician-sponsored organization, which has priority, "is both composed of a substantial number of licensed doctors of medicine or osteopathy practicing medicine or surgery in the respective review area and is representative of the physicians practicing in the review area." A physician access organization is one that "has available to it, by arrangement or otherwise, the services of a sufficient number of licensed doctors of medicine or osteopathy practicing medicine or surgery in the review area to assure adequate peer review of the services furnished by the various medical specialties and subspecialties." The PRO must have at least one consumer representative on its governing board. Payer organizations such as Medicare fiscal organizations in the contract area can be considered if no other eligible non-payer organization is available for a contract. (42 USC § 1320c et seq.)

³Section 1115 of the Social Security Act provides the HHS Secretary with broad discretion for waiving certain Medicaid laws in order to conduct experimental, pilot, or demonstration projects. This allows state and federal governments to implement Medicaid programs that test new and innovative ideas related to benefits and service, requirements and processes, program payment, and services delivery. Some of these demonstrations have sought to serve more low-income, uninsured individuals while achieving cost savings through new program efficiencies.

Chairman THOMAS. Thank you very much.
Dr. Braun, welcome back.

STATEMENT OF BEATRICE BRAUN, M.D., MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS

Dr. BRAUN. I am Dr. Bea Braun from Florida, and I serve on the Board of Directors for AARP, the American Association of Retired Persons.

AARP believes that, because Medicare is both the largest purchaser and the largest regulator of health care in the United States, Medicare standards for health care delivery have an impact throughout the health system. We believe Medicare can set the standard for health care delivery in this country and that Medicare standards should become the basis for a comprehensive Federal framework of quality and consumer protection that applies to all health care plans. And by all, I mean both managed care and fee-for-service, in both the public and private sectors.

In many areas, Medicare has done a good job of establishing what I will call the gold standard. For instance, on paper, the Medicare HMO appeals process is the best in the country. It requires that appeals be decided by a medically qualified outside party which has no ties whatsoever with the HMO. Such independent medical review is very important to consumers who are anxious about whether the plan's decision is really based on their medical needs.

However, there are gaps in the Medicare HMO appeal standards. HCFA says they will be addressed in a new regulation, but we remain concerned that it will not address some of the significant problems we have brought to HCFA's attention: Issues such as shortened timeframes for regular appeals and continuation of care while the appeal is pending.

In addition, there is a substantial problem—and we've heard this before today—that the plans don't follow the required processes and beneficiaries are not being made aware of their rights.

This is part of a larger information gap. HCFA has a great challenge in figuring out how to convey information in a way that beneficiaries can understand and can act on.

For example, much of HCFA's new marketing guidelines for managed care plans actually consist of model communications, forms, letters, and so forth, to beneficiaries, but they're incomprehensible or technical jargon.

However, other managed care initiatives by HCFA make Medicare the leader in consumer protection. We welcome the implementation of the financial incentive regulation and hope that HCFA will devote the necessary resources to evaluating the information it receives, so that we can determine whether a particular type of incentive results in undertreatment.

Similar to the information produced from HEDIS, the CAHPS surveys will offer yet another challenge to HCFA to present information so that beneficiaries can understand and act on it.

There are a number of proposals in the President's budget that ask for authority to implement nationwide ideas that are currently

being tested by HCFA under its research and demonstration authority. These ideas, such as competitive pricing for HMOs, and authorization of provider service networks, or PSOs, show promise, but they have yet to be evaluated.

Congress should give careful attention to any lessons learned from these demonstrations before extending them to the entire Medicare Program.

One proposal in the President's budget already ripe for implementation is the effort to create portability in Medigap insurance—and we heard a little bit about that earlier—by requiring carriers to have a periodic open season in which they accept all applicants. We suggest that Congress go one step further and require a community rating of policies so that beneficiaries have true choice.

There are other things HCFA could do to improve quality and protect Medicare beneficiaries that require no new legislation. HCFA could publish disenrollment and other data it collects, require all plans to submit standardized encounter data, expand the insurance counseling and assistance program, and find new ways to use the Medicare peer review organizations to assure quality in managed care.

In sum, HCFA has undertaken many recent initiatives that will protect beneficiaries and could improve the quality of care for all health care consumers. However, AARP believes there is a need for even stronger, more consumer-oriented efforts if HCFA is to fulfill its responsibility.

All of these things require a significant investment. Congress must see that HCFA has the resources needed to do the job.

Thank you for the opportunity to present our views.

[The prepared statement follows:]

Statement of Beatrice Braun, M.D., Member, Board of Directors, American Association of Retired Persons

Good morning, my name is Beatrice Braun of Spring Hill, Florida, and I am a member of the Board of Directors of the American Association of Retired Persons. I am pleased to present the views of AARP's membership on the state of Medicare HMO Regulation and Quality.

THE BIG PICTURE

To begin with, we must acknowledge the recent intense scrutiny of the practices of managed care plans, both those that serve public beneficiaries, such as Medicare and Medicaid, and those that serve the private sector. AARP believes that this scrutiny is appropriate. Although there is much potential for good in the clinical management of care, many of the recent legislative initiatives reflect the concern of consumers that their care is not being coordinated, but it is being "risk-managed" by actuaries and consultants who set hard and fast rules without any knowledge of a particular patient's clinical circumstances. Opinion polls show that the public strongly believes the government has an obligation to monitor the quality of health care and provide information on quality to consumers. AARP believes monitoring is especially important for public beneficiaries (Medicare and Medicaid) many of whom are more vulnerable than other consumers, and who are not "protected" by employers who are able to intervene with health plans on behalf of their employees. Recent reports confirm that "vulnerable" populations (the very elderly, those with disabilities or chronic conditions, and the poor) may have worse outcomes, greater access problems, and/or less satisfaction under managed care. (E.g., Differences in 4-Year Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems, Journal of the American Medical Association, October 2, 1996; Testimony of PPRC Chair Gail Wilensky, Ph.D., regarding preliminary results of PPRC Access poll, before the Senate Appropriations Labor, HHS and Education Subcommittee, November 13, 1996). Therefore, it is incumbent upon the federal gov-

ernment to be actively involved in oversight and enforcement of requirements to protect the interests of Medicare and Medicaid beneficiaries.

Although a number of targeted proposals have gained momentum and have served to focus public attention on the types of problems being experienced by consumers in managed care, AARP believes that, in the long run, condition-by-condition legislation is not a satisfactory way to regulate managed care. This is because it addresses the symptoms, not the cause. What is needed is a comprehensive federal framework of quality and consumer protection that applies to all health care plans, both managed care and fee-for-service, in both the public and private sectors. Voluntary standards such as those recently proposed by the managed care industry are encouraging, but not enforceable, and give little reassurance to consumers. State regulation, which has made great strides, does not apply to the ever-increasing number of self-insured plans that are governed exclusively under the federal ERISA law. Health services for public beneficiaries (Medicare and Medicaid) are regulated by federal law. Therefore, the only way to achieve comprehensive, uniform quality and consumer protection standards is through federal law.

The yet-to-be-named President's Commission on Quality could be an important vehicle to forge consensus among all the interested parties on a workable set of standards. Many good proposals have been made, and much of the spadework has begun on the state and federal levels. The President's Commission could help to sort through the proposals and create the best framework to achieve our goals.

MEDICARE'S ROLE

Today's hearing specifically focuses on HCFA's activities to regulate the quality of care in managed care plans that serve Medicare beneficiaries. In our view, HCFA must relate to Medicare managed care plans as both a purchaser of coverage and as regulator. To fulfill these dual roles, the agency must make prudent purchasing decisions to ensure optimal use of Medicare funds. In addition, HCFA must discharge its fiduciary responsibility to beneficiaries by ensuring that: (1) plans deliver high quality health care to Medicare enrollees; and (2) appropriate safeguards to protect beneficiaries' access to high quality care are in place. HCFA cannot perform these functions without having appropriate standards or adequate information to assess health plan performance.

We believe that HCFA's success or failure has an impact far beyond Medicare. As the largest purchaser of health care in the United States, the federal government can exercise significant influence by the standards it sets for its contracting health plans. If Medicare specifies requirements, plans are likely to adopt Medicare's practices for their entire population. If Medicare can demonstrate success in improving the quality of care, then Medicare standards become the "gold standard" that other purchasers and regulators will emulate.

With these concepts in mind, we will give you AARP's perspective on how well HCFA is protecting consumers and promoting quality in Medicare managed care. We will address current HCFA initiatives, legislative and regulatory proposals, and give our recommendations for further action that should be taken by HCFA and the Congress.

CURRENT INITIATIVES

I. APPEALS

In some respects, the Medicare HMO appeal process is the best in the country. For example, it requires review of disputes over medical necessity by an outside entity having medical expertise, which has no ties whatsoever with the HMO. This should be a model for private sector managed care. However, there are also some serious problems.

Many aspects of the Medicare HMO appeal process are badly out of touch with beneficiary needs. In addition, beneficiaries don't understand the appeal process and aren't given the information they need to make an appeal. The Office of Managed Care within HCFA has focused attention for the past year on fixing many of the problems, and there have been some improvements, but overall the results have been disappointing. I will talk first about the problems in the appeal process itself, and then about the need to increase beneficiary understanding and knowledge.

Fixing the Appeal Process

The current appeal process needs to be changed, and HCFA's Medicare Appeals and Grievances Initiative, the so-called "MAGI" project was supposed to accomplish that.

The biggest problem in the appeal process is the lack of meaningful time limits. Under current regulations, an HMO can take as long as 60 days to make a formal denial of care and then an additional 60 days to reconsider its denial. Everyone agrees that this is unacceptable. Last fall HCFA promised to issue new rules with tighter time limits, but so far the regulation has not been issued. We have been told that soon there will be a rule setting a short time limit for appeals in cases where a treatment decision must be made immediately. These are usually referred to as "expedited appeals." As for non-urgent appeals, HCFA tells us that a regulation will be published before the end of 1997. We hope that some useful clarifications will be made, but overall, we have little information about what HCFA plans to do.

Consequently, we are concerned that the forthcoming rules will not be adequate. For example, we believe it is essential that there be specific time limits (a certain maximum number of days or hours specified) so that beneficiaries can hold the HMO to them and so that HCFA can monitor compliance by the HMOs. While we expect that specific time limits will be required for expedited appeals, HCFA has not yet revealed to consumers how this issue will be handled with respect to regular, non-urgent appeals.

Another major problem in the appeal process is that current regulations do not require that services which the HMO wants to reduce or terminate continue to be provided until the appeal is resolved. This means that treatment that a beneficiary is already receiving, such as care in a rehabilitation program, can be cut off abruptly and then later resumed, perhaps after irreparable harm has been done, when a decision is finally rendered in the beneficiary's favor. From the little we know about the new rules HCFA is considering, it does not appear that this problem will be eliminated.

We believe that services should continue pending resolution of the appeal, and the beneficiary should not be financially liable for that care even if the final decision is in favor of the HMO. Without such protection, the threat of serious economic loss will deter many beneficiaries from exercising their appeal rights and force them to accept what may be a medically harmful decision by the HMO. The HMOs can avoid or substantially reduce their own financial exposure by giving maximum advance notice and by conducting the appeal rapidly. Hospital discharges are currently handled in this manner. The same approach should apply to all medical services which the HMO wants to reduce or terminate.

Increasing Beneficiary Understanding and Knowledge

HCFA has also undertaken to educate beneficiaries about their rights and about how the appeal process works. The problem is immense.

While the majority of beneficiaries have some idea that they can appeal an HMO decision, a large number do not know when an appeal is available or how it works. The HMOs are supposed to provide this information but often they do not. In many instances, HMOs do not even follow existing appeal procedures. Another serious problem is that beneficiaries often are not told by the HMO that a requested service has been denied, even though Medicare requires that the beneficiary receive written notification. When the written notice is provided, it often does not inform the beneficiary of the right to appeal and does not give any useful information about the reason for the denial. These barriers were the focus of a lawsuit against the Secretary by Medicare beneficiaries in HMOs, and the federal judge hearing the case agreed that failure to provide timely, usable information was illegal. Many of the same problems were also noted in four recent reports published in December 1996 by the Office of the Inspector General of the Department of Health and Human Services.

We believe HCFA should set specific requirements for the content of a denial notice. HCFA has expressed interest in creating a workgroup of plans, beneficiaries and others to create language for the denial notice, and we hope that project will happen. In addition, we believe that HCFA must assure that beneficiaries receive clear, accurate information about the appeal process both at the time of enrollment and every time a service or payment for service is denied. However, we have not yet seen any movement within HCFA to make sure the plans do this.

What HCFA has put a very visible effort into is developing general educational materials for beneficiaries about managed care. For example, HCFA is planning to provide the HMOs with sample letters, notices, forms, etc., to use to communicate with beneficiaries. These documents are part of the "Medicare National Marketing Guidelines for Managed Care Plans," and appeal rights are among the topics covered. I will talk more about those Guidelines in a moment. Perhaps the best thing that HCFA has done to educate beneficiaries was the publication last fall of an excellent booklet entitled "What Medicare Beneficiaries Need to Know About HMO Arrangements: Know Your Rights." We applaud HCFA and the Office of the Inspector General for creating this clear, user-friendly summary of basic rights that includes

a strong section on appeal rights. It shows that complicated subjects can be presented simply, and more importantly, it shows that HCFA is aware of the importance of communicating with beneficiaries. We recommend that, in addition to making it generally available, HCFA send it automatically to every Medicare beneficiary who enrolls in an HMO.

II. MARKETING GUIDELINES

HCFA has drafted a 140 page set of marketing guidelines for HMOs to follow. A portion of the guidelines instructs HMOs on acceptable and unacceptable marketing activities. They are essential for protecting beneficiaries against deceptive and unfair advertising and enrollment practices, and we strongly commend HCFA for acting in this area.

However, most of what is included in the Guidelines does not actually deal with marketing practices. A substantial portion of the document is devoted to providing model language for HMOs to use in the letters, notices, forms and other documents that the HMOs use to communicate with beneficiaries. We strongly support the idea of creating model language. In fact, as better ways of presenting information are developed, we hope that HCFA will consider making some of the model language mandatory.

Our concern about the present draft of the Guidelines is that, with respect to communicating with beneficiaries, it is not yet "user-friendly." The subject of one's rights and obligations as a member of a Medicare HMO is extremely important, and very difficult to present simply. A special effort is needed to do the job properly. In the communications and public relations world, there are experts who specialize in presenting complex ideas to a lay audience. We believe HCFA should tap those talents. A first-class set of communications documents would, in yet another way, make Medicare a role model for the managed care industry.

III. FINANCIAL INCENTIVE REGULATION

HMOs have developed a myriad of payment mechanisms that place physicians at financial risk in order to achieve the cost-conscious behavior that saves money. Financial incentives have great potential to influence the delivery of medical care—for the better or for the worse. Therefore, AARP welcomes the long-overdue implementation of the physician incentive regulations. The new regulations provide HCFA with the opportunity to more closely monitor health plan performance in relation to the incentive arrangements in place. HCFA will need to invest resources both to monitor the implementation and effect of the requirements and to determine whether there is a correlation between different types of incentives and access to care. This will enable Congress and HCFA to determine whether further legislation or rules are required, and whether some incentive arrangements need to be banned.

We also support HCFA's decision to require health plans to disclose certain physician incentive information to consumers, but believe it should go further than the simple summary required by the regulation. Although many consumers do not have the expertise to evaluate the details of incentive arrangements, consumer advocates may have that expertise. Such information should be available to members of the public upon request.

IV. NEW REPORTING REQUIREMENTS

We are pleased that HCFA has issued new reporting requirements for Medicare health plans in 1997: the HEDIS 3.0 measures and the Medicare Beneficiary Satisfaction Survey. These two requirements move HCFA in the proper direction. The data reported by the plans will enable HCFA to establish a data base of information on quality of care in health plans that can be used to hold Medicare contractors accountable for the health care they provide to beneficiaries and to help these plans better target their quality improvement activities.

HEDIS & FACCT

For the first time, HEDIS 3.0, developed under the auspices of the National Committee for Quality Assurance, contains measures applicable to the Medicare population. Of particular importance is the inclusion of a functional status measure (developed with HCFA's support) that will ask older enrollees to rate whether their ability to function has improved or worsened over time. The measure should enable HCFA to assess how effectively health plans are helping their older members maintain their functional abilities. And because HEDIS calls for standardized definitions and specified methodologies, HCFA will be able to compare plan-to-plan perform-

ance. Further, this information will also enable consumers to make valid comparisons about the health plans available to them.

Of course, the HEDIS Medicare measures do not yet provide a complete picture of health plan performance. Additional measures are needed in such areas as institutional care, post-acute care, end-of-life care, and other areas particularly relevant to older persons. Because HEDIS is currently limited to plan-level performance, we will also need measures that permit assessment of care at the provider level. We understand that HEDIS is an evolving tool and that additional measures will be added as they are developed.

To this end, we are pleased that HCFA (in conjunction with the Assistant Secretary for Planning and Evaluation) is supporting measurement development by financing the refinement and pilot testing of three promising sets of outcome measures endorsed by the Foundation for Accountability (FACCT)—for breast cancer, depression, and diabetes. We believe that the lessons learned through this research can result in valuable technical improvements that will have a positive impact on patient care. The FACCT measures are important not only because they have outcomes of care as a primary focus, but because they are intended to apply to the fee-for-service sector as well. The current lack of comparable data for fee-for-service and managed care is a considerable impediment to HCFA's ability to ensure optimal health care quality in the Medicare program. AARP strongly supports HCFA's plans to measure quality in the fee-for-service sector in order to advance our ability to make legitimate comparisons with managed care.

CAHPS

The Medicare member survey that will be used to assess beneficiary satisfaction and experiences with their care is a product of the Consumer Assessment of Health Plans Study (CAHPS) and the collaborative efforts of the Agency for Health Care Policy and Research and HCFA. The survey was designed and developed by the leading researchers in the fields of consumer information and health care quality. It has been tested among consumers and represents the state of the art with respect to content and methodology. An important feature of HCFA's planned implementation is that the survey will be externally administered.

As with the HEDIS data, the CAHPS instrument will permit HCFA and consumers to make valid comparisons across managed care plans. In addition, the new survey is intended for use in all types of delivery systems, including fee-for-service. Therefore, eventually, HCFA will be able to compare the experiences of beneficiaries in managed care with those in the traditional Medicare program. We commend this effort and look forward to seeing the results of the survey, which HCFA has promised to make available to the public by fall, 1997.

In this connection, we recognize HCFA's daunting challenge of producing information from patient survey results that will be easily understood by the Medicare population. For this information to have value to consumers it is critical that the data displays be clear and easily understood.

V. RESEARCH

Through the Office of Research and Demonstration, HCFA is also engaged in several initiatives that will advance our understanding of several issues of importance to consumers.

Competitive Pricing

The Competitive Pricing Demonstration to be launched in Denver will contain three components: a new managed care payment methodology based on competitive bidding; an organized information initiative implemented in a coordinated open enrollment period; and a third-party enrollment broker. AARP recognizes the importance of finding a reimbursement method that will fairly compensate managed care contractors and at the same time set reimbursement at levels that will ensure the appropriate and cost-effective use of Medicare funds. We applaud HCFA's broad-based media approach to providing beneficiaries with objective information about all of the health care options available in a given market, including information about the traditional Medicare program, Medigap coverage, and the managed care plans being offered. Finally, we support the effort to introduce a neutral third party to the enrollment process. We believe that this will help eliminate the possibility of coercion or pressure on the beneficiary at the time of enrollment. It should also help answer the question of whether this mechanism will affect the favorable selection that appears to occur in many Medicare-contracting HMOs.

Medicare Choices

The Choices Demonstration projects will likewise give HCFA an opportunity to test innovations that are being considered for introduction to the Medicare managed care program, including alternative managed care models (e.g., PPOs, PSNs), and risk adjusters. AARP believes that pilot testing these innovative approaches is a sensible way of determining their impact on beneficiaries and program resources, before these approaches are implemented program-wide.

LEGISLATIVE & REGULATORY PROPOSALS

In addition to the activities HCFA is currently undertaking, there are several proposals put forth in the President's Budget that merit discussion. At this point we do not know the full detail of the President's proposals; therefore, our comments are preliminary.

I. ANNUAL COORDINATED OPEN ENROLLMENT

The President has asked Congress for authority to require Medicare contracting managed care plans and Medicare Supplemental insurers to participate in an annual "open season" in which any Medicare beneficiary, regardless of health status, could enroll in any Medicare managed care plan or supplemental (Medigap) insurance. The purpose is to provide "portability" between Medicare fee-for-service and managed care. Although managed care plans are required to accept beneficiaries regardless of health history or condition, Medigap insurers are not (with the exception of a 6-month period when the individual first enrolls in Medicare). As a result, beneficiaries may be unwilling to try managed care for fear that they will be unable to obtain a Medigap policy if they choose to return to fee-for-service. A different version of this proposal that is pending before Congress, would essentially allow a 12-month window to re-enroll in Medigap after trying out managed care.

The President's proposal to require Medigap insurers to "take all comers" has merit and would certainly help foster true choices for Medicare beneficiaries. However, it should be carried one step further, if the goal is realistic choice. Medigap plans should be required to community rate premiums. Increasingly, insurers are pricing their policies through an age-rating process, in which an insured is charged a higher rate the older he or she gets. The practical result is that an older beneficiary may not be able to afford to reinstate a medigap policy, so the choice is not really there. If equal choices are the goal, then medigap insurers, just as Medicare managed care plans, must not be permitted to age-rate.

The coordinated open enrollment, along with the competitive pricing, comparative information, and independent broker elements of the President's proposal are all part of research projects being undertaken by the Office of Research and Demonstrations. As we mentioned earlier, these are promising ideas, but they have yet to be fully evaluated. Before these policies are extended to the full Medicare program, Congress should give careful attention to the pros and cons and consider possible refinements to these proposals.

II. REPEAL OF THE 50/50 RULE

The Administration proposes to repeal the requirement that Medicare-contracting HMOs have no more than 50% of their members be public beneficiaries. This requirement was established to assure that Medicare offered HMOs that were also viable in the private market—to avoid so-called "Medicare mills."

The 50/50 rule is a proxy for quality, but AARP believes we need to have a reliable alternative in place before eliminating this protection. Until HCFA is certain that the new performance reports it receives from plans are sufficient to evaluate the plans, the 50/50 rule should be retained.

III. PROVIDER SERVICE ORGANIZATIONS (PSOs) PHYSICIAN SPONSORED NETWORKS (PSNs)

The President's proposal expands Medicare's managed care options beyond HMOs to include PSOs/PSNs that adhere to certain quality and consumer protection standards.

These "new" organizations typically consist of a physician group or groups in conjunction with one or more hospitals. They subcontract to larger HMOs or contract directly with self-funded employers. They generally cover a smaller service area than an HMO, and have fewer capital financial resources. Some argue that they should be made available to Medicare beneficiaries to broaden choice, and that they

may be able to give an individual more personalized community-based care than a large HMO.

AARP believes that offering beneficiaries additional coverage choices is a good thing—as long as those new coverage options also provide beneficiaries with the quality and consumer protection standards they are guaranteed under other Medicare coverage options.

While some have suggested that PSOs and PSNs should have different standards, and some have even argued for exemptions from standards that other plans have to abide by, we believe strong standards must be maintained. For example, if a PSO/PSN becomes bankrupt, the beneficiary and/or the entire Medicare program suffers. Therefore, strong solvency standards must be required.

Similarly, the Medicare program should not be expanded to offer choices that require beneficiaries to give up their Medicare consumer protections such as quality review and external appeals.

AARP is pleased that the President's proposal appears to extend balance billing protection to beneficiaries who choose the new PSO/PSN option. AARP believes that beneficiaries who choose any new Medicare coverage option should have the protection against physician balance billing that they do under the traditional Medicare program.

As with several of the President's proposals, expansion of Medicare to other types of managed care delivery systems is the subject of an ongoing research and demonstration project. It may be wiser to see what lessons are learned from the project before fully incorporating these systems into Medicare.

IV. REDUCING THE PAYMENTS TO MANAGED CARE PLANS

The President's proposal includes various reductions in Medicare's reimbursement to managed care plans, based on studies finding that plans, on average, are over-reimbursed 5–7%. Plans dispute this and claim that reductions will force them to eliminate additional benefits such as prescription drugs, and that they will have to raise premiums. However, it is difficult to evaluate what the impact will be because plan payment and benefits differ so much around the country. We believe it is up to the plans to respond with actual data demonstrating their costs. It has been widely recognized that the payment methodology currently used to pay managed care plans is inadequate. For the healthiest enrollees, HMOs are overpaid and the Medicare program is essentially wasting precious resources. A more perverse effect of the flawed payment system is that health plans are given an incentive to shun the very patients—those with serious or multiple chronic conditions—who might benefit the most from coordinated, well-managed care—one of the ostensible reasons for offering managed care systems to Medicare beneficiaries. In addition, as more information is provided to consumers, they will begin to discern differences among plans that perform well and those that perform poorly. Publishing performance information about good plans will attract to the good plans those patients most in need of care—i.e., those that are most expensive. If we do not adequately risk adjust payments to plans, the plans that serve sick members best will, in effect, be penalized for doing a good job. Therefore, any adjustment to the payment method should be accompanied by some form of risk adjustment.

WHAT HCFA COULD DO

In addition to current initiatives and pending proposals, there are other activities that could be undertaken by HCFA to bring about improved quality in Medicare managed care.

HCFA should publish the data it collects

As we discussed, HCFA is in the process of developing comparative information about managed care plans. However, as the General Accounting Office recommends in its recent report, HCFA could assist consumers today by publishing the data it already collects on HMO certification reviews, enrollee disenrollment rates and complaints. [GAO Report: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (HEHS-97-23, October 1996)]

Lead the Initiative to Standardize Data

Choosing between managed care and fee-for-service require some means of comparing quality across the board. Standardized data elements and definitions must be established that will allow for fair comparisons and informed choice. Medicare currently has an extensive fee-for-service database of “encounter data,” that physicians and providers collect primarily for claims payment. Managed care entities have resisted reporting such data because they do not routinely collect it (although

many do), and that reporting it is burdensome and costly. HCFA's Medicare Choices demonstration project is experimenting with the reporting of such data by HMOs and we look forward to a full evaluation.

Getting The Word Out

Improved written materials will be helpful, but a multi-media approach to information dissemination must be developed to meet the diverse needs of Medicare beneficiaries. It is important that people know what's available, and how to find it. The information must be "user-friendly." HCFA should be a more active ombudsman, perhaps through expansion of the existing beneficiary Insurance Counseling and Assistance (ICA) program. It is particularly important to educate beneficiaries on how to use comparative information to choose a delivery system, a plan, a physician and a particular medical treatment. It is equally important that they learn how to challenge a treatment decision made by the plan or physician.

Use the Medicare Peer Review / Quality Improvement Organizations

Information initiatives are welcome, but AARP believes that information alone will not be sufficient to assure quality of care—at least not in the foreseeable future. The public expects the government to actively monitor the quality of care, and the need is even greater for public beneficiaries. In particular, we need to find ways to strengthen the role of the Medicare Peer Review/Quality Improvement Organizations (QIOs) in the external oversight of health care. In the QIOs, Medicare has an established network of publicly accountable organizations with expertise in data analysis and clinical care. In the last several years, the QIOs have undertaken significant quality improvement efforts in fee-for-service, particularly in the hospital setting. Their ongoing Cardiovascular Cooperative Project (CCP) has identified substantial variances in the care provided to treat one of the most serious and costly medical conditions—heart disease. The project has demonstrated that there is a great deal of room for improvement in the care of heart patients, and many of the improvements have little or no cost attached. However none of this CCP research encompasses care of patients in Medicare-contracting HMOs. We believe fee-for-service and managed care would each benefit from "cross-fertilization" to achieve better care for all irrespective of delivery system.

At this point, HCFA is working with some HMOs who have agreed to work collaboratively with the QIOs on a test basis. AARP is concerned that these projects are too tentative and that more thought—and determination—need to be put into developing productive ways for the QIOs to provide useful quality improvement services and crucial public accountability to Medicare-contracting HMOs.

THE NEED FOR RESOURCES

The recommendations we make in this testimony will require a significant investment of resources to accomplish. In addition to examining the extent to which HCFA is fulfilling its obligation to monitor quality and making use of the regulatory structures that are already in place, Congress must devote more adequate resources and staffing to do the job.

CONCLUSION

AARP believes that HCFA can set the standard for quality and consumer protection in managed care. No other entity has the combined regulatory and purchasing power of the federal government. Several of HCFA's initiatives are on the right track, but much more needs to be done. Our health care delivery system is changing rapidly and government must move just as expeditiously to protect consumers by assuring and improving the quality of our health care. AARP joins other consumer organizations in offering our assistance to HCFA in carrying out this critical mission. Thank you for the opportunity to express our views.

For further information contact: Cheryl Matheis or Patricia Smith, Federal Affairs Department, (202) 434-3781.

Chairman THOMAS. Thank you, Dr. Braun.
Dr. Johnson.

**STATEMENT OF DANIEL H. JOHNSON, JR., M.D., PRESIDENT,
AMERICAN MEDICAL ASSOCIATION**

Dr. JOHNSON. Thank you, Mr. Chairman.

Mr. Chairman and distinguished members of the panel, my name is Daniel H. Johnson, Jr., M.D. I'm a diagnostic radiologist from Metairie, Louisiana, and president of AMA, the American Medical Association.

Today, I am pleased to offer our views and suggestions concerning some of the most important questions that Congress will face this year; namely, how to improve the Medicare Program, the appropriate standards required to protect our Medicare patients and others by creating a better system, and ways to achieve goals that we all want without having to rely on burdensome regulation.

The protections we're talking about should not have to be legislated, but in our view in the current system they are essential. The AMA believes that the Congress and the administration must take the bull by the horns and agree to fundamentally change the Medicare Program. Only then can cost, quality, and consumer protection measures be made real.

Our vision for transforming Medicare was the basis of our support for reform in the House of Representatives during the last Congress. That proposal consisted of the following: Expansion of the array of choice of different kinds of plans, movement to a defined contribution approach, which would address the concerns you had to Mr. MacDonald, Mr. Chairman, individual selection, and structural reforms to offer and make choices, perhaps modeled after the Federal Employee Health Benefits Plan.

We have a similar vision for the private sector. The AMA believes that providing choice empowers patients. On the other hand, restricting choice expands the need for legislated patient protections.

We are pleased that Congress is looking at the appropriateness of certain medical decisions being made by health plans across the country. Health plans and their effort to increase savings to payers have ignored on occasion fundamental principles that must be followed to assure appropriate medical decisionmaking.

While we support antigag clauses and drive-through delivery and emergency service measures, such as the prudent layperson standard, we believe that more is needed. These issues are only the symptom of a more general problem. The more choice is limited, the more aggravated these symptoms. These issues represent a failure to integrate good medical science with the involvement of practicing physicians and their patients to meet the unique needs of individuals.

We urge all plans to be guided by the following principles, which have enjoyed bipartisan support in the past Congress: In general, plans should disclose to patients plan information, rights and responsibilities, provide for appropriate professional involvement in plan medical policy matters, disclose utilization review policies and procedures, provide opportunity for patient choice of plans and choice of physicians, and provide reasonable access to physicians, both primary care and nonprimary care.

Under no circumstances should gag clauses or gag practices be tolerated. As we told the Subcommittee last July, physicians have

a legal and ethical duty to provide patients with all the information they require. Patients should not fear that third-party payers could interfere with crucial medical information. Therefore, the AMA strongly supports the Patient Right To Know Act of 1997, which is H.R. 586.

We believe to guarantee fairness in the provision of necessary medical services, procedures must be established that provide enrollees and physicians with a system to resolve disputes within the plan. The earlier referred to recent report by the Office of Inspector General cited a number of problems in the risk program.

Due to the nature of the patient-physician relationship, we believe physicians should be allowed to seek participation in plans. Physicians should also have the ability to examine, with the plan, the reasons why participation would not be continued.

We believe that enacting these patient protections is the right thing to do, and we are willing to work with the managed care industry on more comprehensive legislation. But it should be based on restoring the primacy of the patient-physician relationship in the medical decisionmaking process. Until then, we support a more incremental approach.

Our American Medical Association has a 150-year history of standard setting in medical education and ethics. Therefore, the AMA has supported both public and private sector initiatives on assuring quality in managed care and other plans, including our own American Medical Accreditation Program, the so-called AMAP. AMAP is designed to establish national standards of physician performance.

In conclusion, Mr. Chairman, the Medicare reforms we propose are a fundamental shift away from government control toward personal responsibility, individual choice, and an invigorated Medicare marketplace. We do, however, strongly support the need for appropriate patient protections and quality assessment across all plans, even as we move to assure that a competitive marketplace meets the program's goals and responsibilities. What we want to accomplish is to have accountability flow to the patient.

Thank you, Mr. Chairman.

[The prepared statement and attachment follows:]

Statement of American Medical Association, Presented by Daniel H. Johnson, Jr., M.D.

INTRODUCTION

Mr. Chairman Thomas, Members of the Subcommittee, My name is Daniel H. Johnson, Jr., MD. I am a radiologist from Metairie, Louisiana, and President of the American Medical Association (AMA). Today, I am pleased to offer our views and suggestions concerning two of the most important questions Congress will face this year—namely, how to improve the Medicare program and what are the appropriate standards required to protect our Medicare patients by creating a better system that takes advantage of choice and cost effectiveness.

In general, the AMA supports the Health Care Financing Administration's (HCFA) efforts to improve patient protections in the Medicare risk program, such as "anti-gag clause" standards and length-of-stay measures with respect to mastectomies. The AMA also supports many of those aspects of the Clinton Administration's fiscal year 1998 budget proposal relating to quality and patient protections in the fee-for-service Medicare program, including the concept of providing beneficiaries with greater preventative benefits such as colorectal and mammography screenings provided by physicians. We recognize that many Members of the Subcommittee also support the addition of these and other preventative benefits.

The AMA has also supported both private sector initiatives on assuring quality in managed care, including our own American Medical Accreditation Program (AMAP), and many of the concepts contained in managed care reform legislation pending before the States such as "anti-gag clause," "drive-through" delivery and emergency services measures. The AMA believes, however, that more is needed.

TRANSFORMING MEDICARE

While we recognize that this hearing is focused on incremental changes directed at enhancing patient protections and quality assessment, with the Chairman's indulgence, I would like to briefly describe the AMA's vision for Transforming Medicare, which was the basis of our support for efforts to reform the Medicare program in the House of Representatives during the last Congress.

The AMA believes that not until Congress and the Administration are able to "take the bull by the horns" and agree to a plan that fundamentally changes the Medicare program to take advantage of greater patient care, can any real cost effectiveness and consumer protection measures be meaningfully made. The heart of the AMA's updated Transforming Medicare proposal, which has been delivered to every Member of Congress, is based on the following principles:

- Expansion of Choice;
- Movement to a "Defined Contribution" Approach;
- Individual Selection; and
- Structural Reforms to Offer and Make Choices, Perhaps, Modeled on the Federal Employee Health Benefit Program (FEHBP).

The AMA's plan for reform is a competitive market-driven system which offers more choice to senior citizens and the disabled without placing these vulnerable populations at risk. In short, these choices would range from remaining in a restructured Medicare program, to selecting from various competing health plans, including managed care plans, traditional insurance, benefit payment schedules, to investing in a Medical Savings Account's (MSA) (which we were encouraged to see enacted as a pilot project for the non-Medicare population last year). The government would pay the same amount regardless of the patient's choice. While the AMA will continue to work toward comprehensive and structural change in the Medicare program, we understand the necessity of incremental efforts as well.

ESSENTIAL STANDARDS

The AMA believes that while choice should be at the heart of the health care system, health plan standards and empowering patient protections should be its backbone. In other words, if patients are allowed a choice, whether it be in the Medicare program or in the private marketplace, they must also be given the appropriate information to make these choices in an informed manner. Plans must also be given the appropriate clinical information to improve quality and reduce costs. The AMA urges that all plans be guided by the following principles, which enjoyed bipartisan support in the past Congress. In general, plans should:

- disclose to patients plan information, rights and responsibilities;
- provide for appropriate professional involvement in plan medical policy matters;
- disclose utilization review plan policies and procedures;
- provide reasonable opportunity for patient choice of plans and physicians; and
- provide reasonable access to physicians (primary care and non-primary care).

DISCLOSURE

More specifically, plans should disclose information on plan costs, benefits, operations, performance, quality, incentives and requirements to potential and current enrollees. In selecting plans, individuals need information to understand how the plan operates, what they get in benefits, what they must do to ensure that services are covered, and where and from whom they get services. Patients also need to know how plans compare on items such as quality indicators, patient satisfaction, cost control programs, disenrollment rates and grievance and appeals procedures.

Under no circumstances should "gag clauses" or "gag practices" be tolerated. As we testified before this Subcommittee last July, physicians have a legal and ethical duty to provide patients with all the information they require. We believe that patients should no longer fear that third-party payors could interfere with crucial medical information. In this regard, the AMA strongly supports the "Patient Right To Know Act of 1997" (H.R.586), and looks forward to working with you, Mr. Chairman, and Members of the Subcommittee, towards quick passage and implementation of this necessary legislation.

Under the President's budget, as you know, the Secretary of Health and Human Services (HHS) would develop and provide comparative information on all managed care plans in the geographic area. This information would be used by State Insurance Counseling Grant Programs to assist beneficiaries in understanding their coverage options. The AMA supports efforts to provide beneficiaries with comparative information on plan options proposed by the Administration and would extend that assistance to all other options available to beneficiaries. We were encouraged when HCFA, in conjunction with the Office of Inspector General (HHS), recently issued a Medicare Beneficiary Advisory Bulletin entitled, "What Medicare Beneficiaries Need To Know About Health Maintenance Organizations (HMO) Arrangements: Know Your Rights." This advisory bulletin is an excellent example of the type of important information Medicare beneficiaries should have made available to them. The AMA has strongly urged HCFA to require that every Medicare risk contract enrollee be provided with this booklet upon enrollment in an HMO and annually thereafter. We look forward to working with Congress and others in finding opportunities to provide patients with similar information in the private sector.

Furthermore, there are legitimate concerns regarding market segmentation and marketing practices designed to attract healthy enrollees. While plans should be allowed to benefit from competition and their ability to constructively improve the health care delivery process, they should not be allowed to seek out and cover only relatively healthy individuals while avoiding the sicker, more costly, elderly. Marketing practices need to be evaluated as well, and insurance companies should not be allowed to offer physicians and physician groups inducements to reduce or limit medically necessary services provided to patients. The AMA believes that there should be a minimum set of provisions that plans must meet and enrollment procedures that plans must comply with that are fair and avoid inappropriate market segmentation.

To this end, the AMA recently commented on the proposed "Medicare National Marketing Guidelines for Managed Care Plans" issued by HCFA in November. The AMA believes that while HCFA is headed in the right direction, this effort should be strengthened in order to ensure that the Medicare risk program establishes appropriate safeguards. For federally funded programs such as Medicare, it is important to assure that there be a required set of services that each plan provides, with appropriate incentives for preventive service. Plans should have flexibility as to how they provide the services and should be able to enhance the benefit package, consistent with sound medical practice, in ways that meet customer and market needs.

At the same time, plans also need to have arrangements so that enrollees can expect reasonable access to all medically necessary and appropriate care. In order to allow the market to operate, however, there should be several allowable alternatives in achieving these requirements. Under the Administration's proposal, if the Secretary established a standardized package for outpatient prescription drugs, a plan could offer enrollees this benefit only according to the structure established by the Secretary. The AMA is studying the Administration's proposal that would allow the Secretary to establish standardized packages for certain additional benefits offered by managed care plans.

REGULATION OF PLAN POLICIES AND PROCEDURES

In order to guarantee fairness and the provision of necessary medical services, procedures must be established that provide enrollees and physicians with a system to resolve disputes within the plan. In cases where the grievance or appeals cannot be resolved within the plan, participants should be able to seek independent means to address the problems. A recent report issued by the Office of Inspector General (OIG) cited a number of problems found in the Medicare risk program regarding the grievance and appeals process.

Specifically, the OIG report cites problems with beneficiaries not receiving written determinations, including appeals rights, and the need for HMOs to emphasize standardized appeal and grievance language requirements in marketing and enrollment materials and operating procedures. The report also stated that most beneficiaries who were denied services or payment were not given initial determination notices. The AMA looks forward to working with HCFA and Congress on this important issue.

Due to the nature of the patient-physician relationship, physicians should be allowed to seek participation in plans. The AMA believes physicians should also have the ability to examine, with the plan, the reasons why participation would not be continued, for example, where involuntary termination occurs.

APPROPRIATE PROFESSIONAL INVOLVEMENT

We believe that it is the duty of physicians to ensure that their patients receive necessary and appropriate care regardless of the setting or method of payment in which that care is delivered. To make certain that physicians are able to meet this obligation, plans need to provide a process, such as a medical staff, for meaningful physician involvement in the development of medical policies of the plan, including drug formularies. It is also necessary for plans to have procedures and methods that assure that high quality care is provided; yet, plans should also be given some degree of flexibility in order to achieve these standards and to encourage innovations in quality improvement and cost-effective care.

At the same time, we are pleased that Congress is considering the appropriateness of certain medical decision being made by health plans across the country. We believe that the reports of "drive-through" deliveries, "drive-through" mastectomies and "drive-through" appendectomies are not the problem, but only the symptom of a more general problem. The problem is that health plans, in efforts to increase savings to premium payers, have ignored certain fundamental principles that must be followed to assure appropriate medical decision making. We understand that health care plans can no longer can be considered a blank check and we endorse reasonable efforts to restrain costs. The problem that the "drive-through" bills represent is a failure to integrate good medical science with appropriate involvement of practicing physicians and their patients to tailor general guidance to meet the unique needs of individual patients.

UTILIZATION REVIEW

Plan quality management systems and utilization review programs must operate to enhance patient care and be based on sound scientific and medical information. Cost alone cannot be allowed to drive quality. Those who are involved in final decisions should be knowledgeable and qualified in the area they are reviewing. Procedures need to be fair and prompt.

FREE MARKET VERSUS GOVERNMENT INTERVENTION

We note that the physician community is all too familiar with overregulation. We have been subjected to more regulations than we care to think about. We support these patient protections not because we believe in more regulations, but because we believe that the recent opinion polls clearly demonstrate the loss of public support and faith in the health care system. When the insurance and managed care industries confront us on "anti-gag clause" legislation, "drive-through" deliveries and mastectomies," we can not help but think of our own experience in the health care marketplace—especially with regards to the Medicare program.

While we are somewhat sympathetic to the voluntary efforts put forth by the industry, we believe "anti-gag clause" and length of stay for mastectomies legislation should be enacted to help the allay the public's fear, among other reasons, and restore trust in the nation's health care system. We believe that enacting these patient protections is the right thing to do! We are willing, however, to work with the managed care industry to stem the tide of piece meal legislation. Should the industry demonstrate a willingness to develop more comprehensive legislation based on restoring the primacy of the patient-physician relationship in the medical decision making process, we would be interested taking the next step. In our view, Americans want to know that they are receiving all the care that they are entitled to. We all agree that the "bad apples" must not be tolerated.

In this regard we think last week's editorial in the Washington Post, entitled "Health-Care Heavies," may have missed the point. We agree that "gag rules" are wrong. We also agree that physicians are best able to determine which medical procedures are appropriate for an individual patient than are federal or state legislatures. The editorial strongly suggests, however, that politicians have used the managed care industry as a foil thus allowing the industry to make difficult health care cost cutting decisions while also vilifying them for many of their abusive practices. Rather than pointing fingers, we believe a more productive commentary would have included a call for a more comprehensive approach to many of the issues surrounding managed care today. Not until everyone truly puts the interests of Patients First can the debate move forward.

QUALITY ASSESSMENT AND PERFORMANCE

The AMA has undertaken a number of unprecedented efforts in the area of quality assessment and physician performance. As you may be aware, the AMA last year

approved the development of an accreditation program for physicians. Subsequently named the American Medical Accreditation Program (AMAP), the program is designed to establish national standards of physician performance. Last week AMAP took its first step toward implementation and announced that AMAP is now ready to approve self-assessment programs for inclusion in the AMAP program and invited those entities with self-assessment programs to submit them for review. In addition, next week, the AMA will issue its perspective on a set of health plan characteristics that we believe to be essential to the operation of a quality managed health care plan. The document is entitled, "Essential Characteristics of a Quality Health Plan" and quite simply it describes what makes for "good" managed care.

CONCLUSION

The Medicare reforms we propose are a fundamental shift away from government control toward personal responsibility, individual choice and an invigorated Medicare marketplace. We do, however, strongly support the need for appropriate patient protections and quality assessment across all health plans even as we move to assure that a competitive marketplace meets the program's goals and responsibilities.

For further information please contact: Curtis Rooney, M.D., Washington Counsel, American Medical Association, 1101 Vermont Avenue, N.W., Washington, D.C. 20005, (202) 789-7423.

American Medical Association (AMA)
1994-1997 Federal Grants and Contracts

| Funder | Project Name | Type of Funding | Identification # | Product Code | Funding Period | Award | 1997 Rev Recd | 1996 Rev Recd | 1995 Rev Recd |
|-----------|---|--|---------------------|--------------|---------------------|-------------|---------------|---------------|---------------|
| AOA | Teach Phy Role Comm | Coop. Agreement | 90AM070601 | AA69 | 9/30/95 to 7/31/95 | \$61,969 | - | - | \$19,241 |
| CDC | GAPS | Coop. Agreement | U87/CCU510206 | AA59 | 3/15/97 to 3/14/98 | \$787,018 | - | - | - |
| CDC | GAPS | Coop. Agreement | U87/CCU510206 | AA59 | 3/15/96 to 3/14/97 | \$52,044 | \$303,904 | - | - |
| CDC | GAPS | Coop. Agreement | U87/CCU510206 | AA59 | 3/15/95 to 3/14/96 | \$741,187 | \$112,753 | \$421,125 | - |
| CDC | GAPS | Coop. Agreement | U87/CCU510206 | AA59 | 3/15/94 to 3/14/95 | \$372,396 | - | \$108,370 | - |
| CDC | Physician HIV Kit | Coop. Agreement | H62CCCH5110010 | AA56 | 9/30/94 to 12/31/94 | \$75,000 | - | \$66,636 | - |
| CDC | Family Violence Conf | Coop. Agreement | R13/JCCR510373 | AA64 | 3/1/94 to 2/28/95 | \$50,000 | - | - | - |
| CDC | Immunization Project | Purchase Order | 94B2539 | AA35 | 7/13/94 to 3/16/95 | \$25,000 | - | \$24,980 | - |
| DHHS/ PHS | Indian Health Service Corps | Project USA | 282-95-0008 | DA47 | 1/3/95 to 1/29/96 | \$1,642,650 | \$531,032 | \$547,521 | \$564,097 |
| EPA | Indoor Air Program | Coop. Agreement | CXK23762-01 | AA39 | 9/1/94 to 8/31/95 | \$115,000 | - | \$12,527 | \$84,999 |
| EPA | Indoor Air Program | Coop. Agreement | CXK23762-01 | AA39 | 10/7/95 to 10/6/97 | \$27,524 | - | - | - |
| HRSA | Family Violence Conf. | Coop. Agreement | HRSA94-335P | AA64 | 1/1/94 to 12/30/94 | \$15,000 | - | \$15,000 | - |
| HRSA | Basic Data on Physician Characteristics for BHPR Analytical Program | Physician Masterfile Data | 240-BHPR-14 | DA14 | 8/20/95 to 8/31/95 | \$239,760 | - | - | - |
| MCHB | PIPPAH | Purchase Order | 103HR851215P000 | AA62 | 9/15/95 to 7/31/96 | \$40,000 | \$40,000 | - | - |
| MCHB | PIPPAH | Coop. Agreement | MCL-17A304-01-0 | AA62 | 10/1/95 to 9/31/97 | \$100,000 | - | - | - |
| MCHB | Healthy Youth 2000 | Coop. Agreement | NCJ-177524-01 | AA75 | 10/1/95 to 5/31/96 | - | \$24,267 | \$13,672 | - |
| MCHB | Healthy Youth 2000 | Coop. Agreement | NCJ-177524-01 | AA75 | 10/1/94 to 9/30/95 | \$91,845 | - | \$42,440 | - |
| NLJ | Family Violence Conf. | Coop. Agreement | 96-JL-CX-0029 | AA44 | 5/1/96 to 12/31/97 | \$50,000 | - | - | - |
| NLJ | Family Violence Conf. | Coop. Agreement | 94-JL-CX-K003 | AA64 | 1/1/94 to 12/30/94 | \$100,000 | - | \$34,043 | - |
| USAID | US Agency for International Development | Coop. Agreement to Advance Russian Healthcare System | 18-004-A-00-6226-00 | - | 9/27/95 to 3/31/98 | \$356,000 | - | - | - |

FUNDER LEGEND: AOA - Administration on Aging; CDC-Centers for Disease Control and Prevention; EPA - Environment Protection Agency; HRSA - Health Resources & Services Administration;

MCHB - Maternal and Child Health Bureau; NLJ - National Institute of Justice

PROJECT LEGEND: GAPS - Guidelines for Adolescent Preventive Services; PIPPAH - Partners in Program Planning in Adolescent Health

Chairman THOMAS. Thank you very much, Dr. Johnson.

You indicated support for H.R. 586. Did you know that the Patient's Right To Know Act, as it's called, or the Antigag Rule Act, H.R. 586, excludes group practices? And would you be supportive of excluding group practices from the Patient Right To Know Act, or would you be in favor of including them? Provider-sponsored organizations are excluded from the Patient Right To Know Act.

Would you be in favor of excluding them or including them.

Dr. JOHNSON. No, they should be included. They should be—

Chairman THOMAS. You need to know that the legislation you just indicated your support for excludes group practices and provider-sponsored organizations, so I appreciate the statement and I'll get to the author, Dr. Ganske, and indicate the AMA's desire.

Would you like to have me indicate that we should amend it to include group practices?

Dr. JOHNSON. As you wish, Mr. Chairman. You're the legislator and—

Chairman THOMAS. And you're the American Medical Association, and you've indicated in your testimony that plans should disclose information on plan costs, benefits, operations, and so forth, and so forth. You're more than willing to make sure that information from plans should be made available.

In the spirit of this new interest in the patients' concerns, would the AMA also support information being made available from the National Practitioner Data Bank Information on Malpractice?

Dr. JOHNSON. As I hope you are aware, we have expressed concern over time in the way the data bank provides that information and the quality of the information provided.

As we look to new and better ways to present information to patients, to help them make decisions, not only with respect to plans but to their individual physicians, we think any and all information should be available to them. But it should be offered in a way that is productive and helpful to them in making the correct decisions they need to make.

Therefore, we have considerable concern with the data bank. If it can be made to work better, we may change our attitude.

Chairman THOMAS. Do you have any initiatives going on inside the AMA which could allow us to get quality information from doctors, in terms of those kinds of questions, and especially the concerns that you outlined for the plans, so that we could begin to make comparisons between fee-for-service and the plans?

I know it would have to be voluntary within the AMA structure, but that kind of a willingness to move in the direction of your own structure providing this kind of useful information would encourage me, in terms of the motives and concern about your desire to make sure that others have that information provided as well. Do you have any initiatives at all now going on?

Dr. JOHNSON. Yes, we do. Mr. Chairman, I appreciate the opportunity to comment additionally on that.

You will recall a moment ago in my testimony I mentioned AMAP, our accreditation program. I am proud to tell you that, in

the 150-year history of the American Medical Association, this is the largest single enterprise that we have ever undertaken.

It has five components, not all of which can be accomplished overnight. This will require a continuum of effort. But we will begin with the credentialing process, which is driving both the various plans which want to credential their enrolled physicians, their participating physicians, if you will, hospitals, who have to judge the qualification of physicians, as well as patients who wish to select their physicians. It's absolutely crazy, the duplication and cost here is enormous. There are some scattered efforts to fix that around the country, but we hope to collect that under one umbrella, if you will. Not to take the place of someone else who is already doing a good job.

But then it extends beyond that, to the notion of assessing the personal qualifications of the physician, what his or her ability is to deliver the services. We want to ultimately get into assessment of the environment of care; that is to say, the facility, no matter what type of vertical or horizontal integration, solo or large multi-specialty groups, but to enable us to be able to determine something about the environment of care in which physicians' services are delivered to patients.

As we move on, the next two and last two of the five become somewhat more complicated and will be harder to do. You have already heard considerable testimony about clinical performance today.

We support and have supported outcomes research. The AMA has been engaged for years now in attempts to develop practice parameters, which are tools to help physicians know what works best in a given situation.

Finally, to measure all of that in a way that is meaningful, and hopefully that is cost effective—outcomes research is very expensive—but systems processes are already in place in different areas around the country which are showing us it is possible, particularly with modern techniques, to gather that information in a cost-effective way.

Wrap that all together and it is a very comprehensive program that we're very proud of, Mr. Chairman, and we're proud to offer to the country.

Chairman THOMAS. I appreciate the efforts you are expending. A hearing hasn't gone by where I haven't already done it, in terms of mentioning outcomes research.

It just seems to me that that, of course, is an attempt to determine what really works, notwithstanding what someone says works, by taking a lot of data and comparing what occurs.

Do you think it would be an appropriate first step to have those doctors who perform similar operations in large urban areas be required to publish their success rate, or the types of outcomes of operations that have occurred, so patients can see that information and have it made available to them to make choices? Would that be appropriate, or would that be similar to the malpractice data that is currently compiled?

Dr. JOHNSON. Once again, what the information means to the consumer can be very misleading. So to the extent that we can develop outcomes that—

Chairman THOMAS. Would it be informative in any way at all to the consumer, if someone has a success rate in a particular type of operation, versus someone who has less of a success rate?

Dr. JOHNSON. Some of the comparative data, for example, that's been done, illustrating radically different practices in one community versus another, from university settings, theoretically, the "ivory tower" physicians in those two areas, and yet they come up with different results and different approaches to the same problem—

Chairman THOMAS. Wouldn't those circumstances be similar in managed care plans, depending upon where they are, the facilities they use, and the patients they look at?

Dr. JOHNSON. It's a dilemma for the managed care plans as well.

Chairman THOMAS. But you've got testimony here which requires them to present all of that information now. Why would they be that much different, based upon what you said, from what's going on in the situation that you outlined, which might give misleading information to the patient?

Obviously, since I'm the only one here, I feel compelled to make sure both sides are upheld, in terms of the questioning of the panel.

But I think at some point the arguments that have been made historically begin to pale. I guess what I'm saying is, Get on with that fourth and fifth step of the program that you're focusing on. We need to see movement in that area.

You can say some more, but you don't need to because I'm looking for measuring tools, I'm looking for product.

If you will allow me to turn to Miss Ignagni now, I like your Putting-Patients-First policy. As you know, I implored you to do this some time ago. My problem is, notwithstanding the efforts that you've now shown in which you have moved forward, in terms of, as an organization, providing broader standards as suggested adoptions, but your association doesn't cover all of the managed care organizations.

What do we do with those folks who are not smart enough to join your organization, or who may, Heaven forbid, leave because you're now actually doing something which might require them to rethink the way in which they're operating?

Ms. IGNAGNI. That may demonstrate the straightforwardness of the effort, and maybe, in many ways, that would be an interesting state of affairs.

Mr. Chairman, we represent over 90 percent of the industry. What I would like to report to you is that this is a grassroots effort. This came from listening to our physicians and our patients.

Basically, what we heard, very frankly, was that they thought it was very important for us to step forward, clarify what we do, and speak very straightforwardly about what it is. So I'm very happy to report that all the things on Dr. Johnson's list have been embodied in this initiative.

I think, as part of that process, we have raised the bar very significantly. We've held this up and our plans up, at their request, to public scrutiny and accountability, and our members think that that's the right thing at the right time.

At the same time, we are prepared to engage with you and this Subcommittee in a process of looking at what else is going on in the regulatory playingfield, both Federal as well as State, what needs to be done, and to talk about the role of government to preserve a marketplace that is dynamic, but at the same time protect consumers and make sure that providers are fairly and equitably treated.

We support those objectives and we want to engage in these discussions.

If you will allow me just to say another postscript, I think what has been happening over the last several months is the matter of the role of government has really come into question, and there seems to be a difference of opinion between the role of government as a standard setter versus a micromanager. I think this Subcommittee has indicated its interest in sorting one out from the other, and we would like to help in that process.

Chairman THOMAS. Obviously, I'm not interested in legislation body part by body part. It doesn't make a whole lot of sense. As a matter of fact, we just heard testimony earlier that HCFA apparently doesn't think it makes a lot of sense, that the appropriate ultimate determiner would be the physician and the patient, and we can only hope that that would be the outcome. However, I am concerned over the number of bills that have been introduced which would, in fact, impose a legislative political determination on the outcome. It's almost inevitable.

Let me say to a certain extent that this may have been generated, whether it's wholly merited or not, by some folk who are willing to test the boundaries. And by testing the boundaries, they wound up finding out that someone was going to utilize government because, to me, government in large part is the process of politics, which is determining who gets what, when, and how. We now have to try to indicate—I won't say belatedly, but certainly at the 11th hour—that there is a willingness to self-impose what an informed layperson would think would be a responsible position in dealing with these issues.

As long as I see a degree of responsibility out there, I am more than willing to try to step into the breach to stop bills moving that probably make less sense than they should, in the way they're dealing with it. We may have to examine the content of the legislation and modify it, rather than oppose it.

I guess my biggest concern—and, Dr. Braun, I want to bring you into this, because I don't know that I have the same faith that you do in government, in terms of setting the standards. The earlier panel talked about how far behind HCFA is from many more enlightened private sector folk, in terms of the type of information that you're giving.

The answer to this I hope is obvious, but saying it and then making it happen are always two different things. That is, I would love to see the private sector, the professionals, and those who have a direct interest in the outcome, come together to provide us with the model structure that would be necessary.

Then, you see, you allow HCFA to maintain those standards that are agreed upon as appropriate, rather than having the kind of standards generated out that always wind up micromanaging and

bureaucratic far more than anyone intended, when you have an agency like HCFA involved.

But obviously, we want the best tools available to make sure people get the most for their money. But, frankly, when you talk to the private sector, we are so far behind in setting the kinds of standards, given the changing marketplace and the changing delivery of health care, that I don't know that it makes a lot of sense to then give the resources—I think you heard Dr. Vladeck very plainly say he's not going to dedicate the kinds of resources that we probably need, even in a very aggressive educational-informational program. So I guess, at best, we could say we would get a mixed bag of results from Medicare.

Am I "Pollyanish" too much to think we might be able—because when we legislate, the easiest way when you're dealing with an issue in which there is controversy is to have the various folk come together, agree, and then give us the solution. Boy, I love those bills. I haven't seen too many of them in the time that I've been here.

But that's the thing that makes sure the standards are appropriate and they don't go too far. Because I believe it was the gentleman from Nevada who clearly indicated, Once you get it locked into law, it's extremely difficult to change it. And when you're trying to legislate in the area of standards, quality, outcomes, if you aren't very general, in my opinion you can get in trouble very fast.

Where is AARP—or, frankly, I'm more interested in your opinion as a medical doctor—in insisting that it be the government that determines the standards? My assumption is, absent the ability of the private sector to meet the consumers' satisfaction, they're the only ones left and you're already looking to them as the final solution. Or do you think we can get groups together?

Dr. BRAUN. I think, Mr. Chairman, that for Medicare, which is the government, if you want to say so, they are the purchaser and they should have the same responsibility any purchaser in the private sector has, to be sure standards are being met, that their beneficiaries have the information they should have. So I really see them as similar to the GTE or whoever in the private sector is purchasing the health care for their employees.

They happen to be the largest, and what you're saying is very true, because the bigger you get, the more difficult maybe it is to keep up.

Chairman THOMAS. Would it offend you if we found in the private sector some standards that seem to be appropriate and working and we moved them legislatively to impose them upon Medicare rather than letting HCFA grow their own?

Dr. BRAUN. I think we would have to look at that certainly, but I'm sure—

Chairman THOMAS. But that doesn't offend you as an approach?

Dr. BRAUN. No, we would certainly, I'm sure, support standards that are working elsewhere. To get HCFA moving has been our desire, like yours.

Chairman THOMAS. I think the recent introduction of legislation indicates that if people don't want other people to legislate standards, those who are concerned about the legislation really do need to get together fairly quickly, notwithstanding the argument that

timing is always difficult to make it happen, to start offering some very real world substantive options, so that we can counter it, rather than say that's not a good way to go forward.

If they have something and we have nothing, the chances are eventually they will put something in, and my concern is, if it isn't right, it will be extremely difficult to get it out, if ever. So I guess I'm imploring you folks to get together.

I'll try to generate inside HCFA decent standards, as you indicate in your testimony. I hope when you say the Federal Government can exercise significant influence by the standards it sets, that you didn't really mean narrow, rigid, quality consumer protection standards that get locked in, that impede medical progress, but rather, provide a clear standard in which you can get some quality adjustments for people who are paying a fair price and want a fair product.

Dr. BRAUN. Yes. I think certainly the private sector and the public sector can help each other in getting appropriate standards.

Chairman THOMAS. The other side is the quasi-private sector, and I guess the answer is, If you folks don't do it, someone else will, and neither one of us probably will enjoy the work product of someone else doing it.

I look forward to standards, notwithstanding probably involving only 90 percent of the industry. I think the idea of looking at models, for example, the one that was provided on the patient right to know by HCFA, that was, in essence, adopted by your group is useful. So there are times when HCFA offers a standard and if it's appropriate, it ought to be adopted, ought to be applauded. When they come out with something that doesn't make a lot of sense, we ought to offer something different.

There are enough models out there and you should get them to us and we'll try to use those as the standard in place of the other.

But I will tell you that we do not have a lot of time. There is pressure in this body, and in the other body, that absent a relatively quickly found remedy, legislation will move. My hope is it's a fad. My hope is that, as time passes, sounder heads will prevail. But, frankly, there are press conferences at the White House urging these solutions on folk, notwithstanding the more professional folk inside the administration communicating to others a different message. The ultimate message should be that it will be between the patient and the physician. But I do believe we need a far better educated patient as a consumer, so that they can make good choices along with the assistance of their physician.

Does anybody want to comment?

Dr. BRAUN. I think the reason, Mr. Chairman, that a lot of these things have come in pieces is because those medical decisions have been taken away from the physician. I really think, as you were saying, that is the crux of the problem, that those things need to be decided between physician and patient.

Chairman THOMAS. And you need to know there is broad-based support. If the decision for the physician would be the medical decision, I think you will find that, under the rubric of the patient's right to know, there is a significant amount of wages and hours, legislative concerns, and a number of other activities—

Dr. BRAUN. I'm not getting into the patient's right to know. I'm just saying the basic—

Chairman THOMAS. I understand. But I think you will find, as I said, if the legislation actually covered the ability of a physician to advise the patient on the medical propriety of what it is that's available, notwithstanding the limits in any program—because all programs are somewhat limited—that you wouldn't get much objection. I think what you find is, oftentimes, when you read some of this legislation, under the rubric of the patient right to know, it basically ends up the doctor's right to withhold information. That isn't the goal of any of us because it falls over into religious and moral beliefs as well. There's just a whole morass of an area where the product moving through the legislative process winds up getting exposed to.

Our goal is to make sure, where we agree, that's the outcome. Isn't that fun? With nobody else around here, we can say that. And to the degree you provide me with rational alternatives to some of those options that are out there, I pledge to you I will do the best I can to make it happen.

Thank you very much.

Dr. BRAUN. Thank you.

Ms. IGNAGNI. Thank you, Mr. Chairman.

Chairman THOMAS. The Subcommittee stands adjourned.

[Whereupon, at 3:58 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of American Academy of Family Physicians, Kansas City, Mo.

INTRODUCTION

This statement on Medicare health maintenance organization (HMO) regulation and quality is being submitted today on behalf of the 84,000 practicing family physicians, family practice residents, medical students and other individuals with an interest in family medicine who comprise the membership of the Academy.

FAMILY PRACTICE AND MANAGED CARE

The Congressional Budget Office recently predicted that approximately one-third of Medicare beneficiaries would be enrolled in HMOs by the year 2007. According to the Health Care Financing Administration (HCFA), the percentage of program beneficiaries enrolling in Medicare HMOs has tripled since 1991. Today, approximately 10 percent of Medicare beneficiaries are enrolled in managed care plans. As the number of Medicare HMO enrollees rises, delivering health care services to this population is becoming an increasingly important feature of the typical family physician's practice. In a study conducted by the Academy last year, 36.5 percent of practicing family physicians reported that their patient load includes Medicare HMO enrollees (AAP 1996 Practice Profile 1 Survey). This survey also found that for the practices accepting new Medicare beneficiaries, 15.4 percent of them are accepting the program's managed care enrollees.

As the nation continues moving toward managed care, it is clear that family physicians are ideally suited to caring for Medicare HMO enrollees. This compatibility stems from the extensive breadth of medical training that family physicians undergo, making them qualified to treat more presenting conditions in the male and female patient, regardless of age or affected organ system, than any other type of physician. Family physicians practice effective preventive medicine and can detect problems early, before health problems require expensive treatments. Family physicians also know when their patients need more specialized care and how to help their patients obtain that care. It is for these reasons that managed care plans extensively utilize family physicians.

THE CONTEXT FOR CHANGE IN THE MANAGED CARE ENVIRONMENT

The delivery of coordinated, high quality and cost-effective health care is the frequently achieved goal of most managed care plans. Indeed, a majority of the Medicare beneficiaries enrolled in HMO plans are satisfied with their care, according to HCFA. However, the Academy readily acknowledges that some HMO business practices pose serious access, treatment and quality problems. While nearly one-half of all practicing family physicians are involved with managed care plans, we are no less troubled than the general public by news of HMO patients facing inappropriately denied medical treatment or by reports of hassles by unresponsive or uninformed HMO personnel. In a perfect world, all health insurance plans would cover the expense of any service that an enrollee's physician determined to be medically necessary. Given limited resources, however, we must be sensitive to cost but without sacrificing the quality of care.

As an organization committed to outcomes-based medicine and the sanctity of the physician-patient relationship, it is difficult for the Academy to accept solutions that are based not on science, but on the exigencies of public pressure. We are greatly concerned with congressional intervention into medical practice. While decisions by some managed care plans that adversely affect patients are unacceptable, we question the appropriateness of solutions based on legislative mandates. As the health care delivery system matures and as quality becomes more paramount, we expect that physicians, patients and health plans will address quality issues without congressional intervention. We do not believe that legislation or regulation of any sort should interfere with clinical decision-making. This is the core principle upon which the Academy bases its actions on proposals to regulate the managed care industry and other health plans.

This position is the basis for the Academy's endorsement of H.R. 586, the Patient Right to Know Act introduced earlier this year by Representative Greg Ganske (R-IA) and Representative Ed Markey (D-MA). Some health plans unfortunately "gag" their health care providers by forbidding them from communicating freely with their patients about their medical or mental condition, treatment options, or health plan policies that may influence payment for a medically necessary service. Unfettered medical communication is, however, undeniably in the best interest of patients; it is absolutely essential for the delivery of the highest quality health care; and, it is intrinsically linked to upholding the code of medical ethics that all physicians must follow. The Ganske-Markey bill would correct this problem with gag clauses that hinder physician-to-patient communication about clinical decisions, and it is for exactly this reason that the Academy wholeheartedly endorses H.R. 586.

By contrast, the Academy is disturbed by attempts to improve HMO quality and protect consumer interests that result in the government establishing standards of medical practice; that is, in making the government the manager of clinical decision-making. The postpartum length-of-stay law enacted last year illustrates our concern with this aspect of HMO regulation. The postpartum hospitalization law represents a well-intentioned response to the problem with some health plans' payment rules influencing new mothers and infants to leave a hospital or birthing facility 24 hours or less after the delivery. However, the law has in reality established a de facto standard of medical care—regardless of what period of hospitalization the physician and patient would mutually determine to be the appropriate postpartum hospitalization period. Intervening directly in the process of clinical decision-making defeats efforts to provide the highest quality and most cost-effective health care services to patients, and it is for this reason that the Academy cannot support policies, such as the postpartum length-of-stay law, that position government to direct clinical decision-making.

The Congress already is feeling the repercussions of the precedent set by the postpartum hospitalization law in this session as concerned lawmakers introduce new bills that would essentially require the government to establish standards of medical practice on a case-by-case basis for various conditions or treatments. Post-mastectomy length-of-stay in a hospital, for example, is now attracting the attention of many lawmakers. We do not believe that Congress ought to attempt to establish itself as the adjudicator for each disputed HMO practice.

ISSUES RELATING TO QUALITY

The evolving field of quality measurement and improvement offers new opportunities to help ensure that the health care patients receive in all settings is optimal, outcomes-based, provided by a qualified provider and meets the expectations of the patient. The continuum of quality from the viewpoint of physician-provided health care ranges from the credentialing of the physician to assessing what the physician did through the measuring of outcomes of care to determine patient satisfaction.

Unfortunately, to date, the cost pressures of managed care have often resulted in a narrow plan focus on how to reduce expenditures in the provision of health care services with less real emphasis on how to improve quality, and actually place value on quality. Ironically, the two goals can be complementary; with quality care often being the more affordable option. The example of management versus surgery for urinary incontinence illustrates this point. An individual experiencing urinary incontinence may receive bladder suspension surgery requiring weeks of recovery time before returning to full activity. However, for many forms of urinary incontinence, the same patient could also be trained by a primary care physician in behavioral control techniques to manage the incontinence through education about the condition, medication, and exercise that involves little to know adverse health effects. It is this course of treatment that was recommended in the guideline for treating urinary incontinence developed by the Agency for Health Care Policy and Research (AHCPR) in 1992. Today, bladder suspension surgery alone costs \$823.71 to \$1,026.87 (CPT Codes 51845 and 53440 respectively) whereas a mid-level office visit to the family physician is only \$36.48 (CPT Code 99213). Although the number of office visits for urinary incontinence management will vary by patient, the costs associated with this course of treatment are still far below the cost for surgery. High quality health care at a reasonable cost can be achieved through management of urinary incontinence, instead of surgery, as demonstrated by both these CPT figures and the AHCPR guideline. Greater attention to this sort of quality improvement will result in better health care for all patients regardless of the type of their insurance or health plan, and an improved health care system in general.

The Academy is committed to taking an active role in developing and implementing strategies to improve the quality of care provided by Medicare HMO plans and other health plan options. We will seek opportunities to partner with the public and private sector in these efforts to design policies that will improve the health care system in general, subject to the following specific principles:

- All quality improvement and measurement efforts must be patient-centered, evidence-based, and practicing-physician friendly;
- The advice and counsel of practicing physicians must be sought from start to finish as part of quality improvement and measurement activities;
- Solutions to quality problems in the health care system, or with health plans, must be outcomes-based and developed by patients, physicians and health plans preferably without congressional intervention;
- Board certification must not be used as the sole criterion for physician exclusion from health plan participation participation decisions should be made on the basis of training, demonstrated competence, continuing medical education experience and other relevant information; and
- The activities of the Agency for Health Care Policy and Research (AHCPR), and in particular for primary care research, deserve explicit support and adequate funding to carry out its work, which is entirely consistent with efforts to improve the quality of health care services delivered to Medicare HMO enrollees and other patients of this nation.

PRINCIPLES RELATED TO MANAGED CARE PLANS AND UTILIZATION REVIEW

The Academy developed the following principles to assist individual family physicians or groups of family physicians in their efforts to work with managed care organizations to provide high-quality, cost-effective health care to enrolled populations. We believe these principles offer useful guidance for the operation of HMO plans participating in the Medicare program. The principles are as follows:

- Managed care plans should provide sufficient information about plan terms and conditions to allow prospective enrollees and patients to make informed enrollment decisions;
- Physicians must be able to discuss any information, clinical or financial, necessary for their patients to make informed decisions regarding their medical care;
- Managed care plans should demonstrate that they can provide sufficient access to physicians and other providers so that all covered medical services are provided in a timely fashion;
- Managed care plans should develop contracting criteria for physicians. Such criteria should be available for review by physicians and should be utilized in determining physician selection, retention and disenrollment;
- Managed care plans should have sufficient financial reserves to ensure proper and timely payment for covered services;
- Managed care plans should establish a mechanism by which physicians enrolled with the plan can play an important role in developing the plan's medical policies;

- Managed care plans should periodically provide to each physician data to evaluate his or her performance relative to stated plan performance criteria and in relation to a comparable group of plan physicians which are age, sex and severity adjusted;
- In regard to physician disenrollment, managed care plans must provide physicians with the reason for disenrollment, the right to appeal the disenrollment decision and sufficient notice of disenrollment to allow for the orderly transfer of patient care responsibilities;
- Medical directors of utilization review programs should make coverage decisions based on clinically sound guidelines, however, physicians should have the right to appeal adverse coverage decisions and have such decisions reviewed by another physician with the same expertise and of the same specialty;
- Utilization review programs must respond to requests for prior authorization of a service within two business days;
- Whenever practical, potential enrollees should have a choice of health plans at least one of which should include a point-of-service option;
- Managed care plans may impose an additional, actuarially justified premium and higher patient cost-sharing requirement for "out-of-network" care;
- Economic or capacity profiling of a physician must be adjusted to recognize case mix, severity of illness, age of patient and other features of a physician's practice that may account for higher than, or lower than, expected costs;
- Managed care plans should not discriminate against individuals with expensive, long-term or chronic medical conditions by excluding such patients (i.e., pre-existing conditions);
- Managed care plans should not discriminate against members of high risk, vulnerable, or other similar patient populations by excluding physicians with practices containing substantial numbers of such patients; and
- Managed care plans should not utilize any criterion that excludes a physician based on sex, race, creed, national origin or any other factor prohibited by law.

RECENT GOVERNMENT ACTIONS TO PROTECT MEDICARE HMO ENROLLEES

HCFA deserves praise for publication last year of the Medicare Beneficiary Advisory Bulletin on HMO Arrangements. This bulletin identifies potential fraud and abuse issues related to the enrollment, the provision of services, and the discontinuation of Medicare program beneficiaries in HMO plans. It is provided free of charge through many consumer groups, health care associations, and was printed in the Federal Register on November 15, 1996. The information contained in the bulletin is stated in "plain English" and should be easily understood by consumers. It provides readers with information about the basics of managed care, such as expectations for care and referrals, and how to appeal an adverse referral or treatment decision, among other useful advice. The effort to help citizens familiarize themselves with the basics of managed care is desirable in and of itself. More importantly, this pamphlet should assist consumers with evaluating competing managed care plans and selecting the one best suited to their needs.

For this first time this year, HCFA is requiring all Medicare HMO plans to implement eight outcomes measures developed as part of the Health Plan Employer Data and Information Set (HEDIS) 3.0, including a functional status outcome measure, that should help the agency to more accurately evaluate the quality of health care provided to Medicare beneficiaries. The results of reporting on these HEDIS 3.0 measures it is hoped will assist participating health plans with improving the quality of care delivered to their enrollees. The Academy collaborated with HCFA during the development phase of these quality measures and supports their usage.

THE ADMINISTRATION'S FISCAL YEAR 1998 BUDGET PLAN

The budget proposal released by President Clinton on February 6 includes a limited by welcome set of measures designed to modernize the Medicare HMO program and modify the method by which the Medicare program pays participating managed care plans.

The budget would require, among other things, that both Medicare HMO plans and Medigap plans establish an open enrollment period and that pre-existing condition exclusions would be banned. The Academy supports the notion of a coordinated annual open enrollment period for Medicare HMO plans and Medigap plans because such a policy would promote continuity of care for beneficiaries. Under current law, the ability of beneficiaries to switch health plans on a monthly basis, if they choose to do so, can disrupt the continuity of health care services and diminish the quality of health care. Pre-existing condition exclusions prevent many Medicare beneficiaries from enrolling in certain managed care plans seeking to "pick" only the

healthiest and youngest beneficiaries as subscribers. As long-standing supporters of universal coverage and health plan freedom of choice, the Academy wholeheartedly approves of protecting consumer interests through a ban against pre-existing condition exclusions by Medicare HMO and Medigap plans.

In addition, the administration's budget proposes to alter the method by which Medicare reimburses participating managed care plans. Under the current method, Medicare HMO plans are paid 95 percent of the average annual per capita cost (AAPCC) provided for fee-for-service care in a county. Under this method, monthly payment rates for Medicare HMO services vary greatly across geographic areas, from \$221 to \$767. The administration budget would establish a \$350 minimum HMO payment for areas with below-average payment rates, effective in 1998, so that more Medicare beneficiaries could select a managed care option. A recent study based on HCFA data and distributed by the Fairness Coalition demonstrates clearly that enrollment in Medicare managed care plans is lowest in those areas where the AAPCC payment rate is below \$350. For example, less than 1 percent of Medicare beneficiaries in counties with an AAPCC payment rate below \$300 per member per month are enrolled in managed care plans. By contrast, 76 percent of Medicare beneficiaries are enrolled in managed care plans in counties where the AAPCC payment rate exceeds \$400 per member per month. While the Academy has not endorsed a particular method for adjusting the AAPCC, we do support the idea of adjusting it toward a national average amount that would apply in all counties. Given that the AAPCC rate in most counties is below the national average at this time, bringing up the floor would be beneficial for most existing Medicare HMO plans. The Academy believes that consumers would benefit from the ability to select between fee-for-service and viable managed care options in their communities as a result of this suggested change.

Some observers have expressed concerns that the AAPCC modifications in the budget plan might diminish quality and harm consumers in the areas in which payments to HMOs are highest by forcing the plans serving those areas to cut back on their supplemental benefit packages, as their payments are lowered to raise the floor in other areas. These supplemental packages typically include low-cost prevention services, prescription drugs, eyeglasses and hearing aids. The Academy is sensitive to these concerns and believes changes ought to be carefully considered and monitored with equal care as they are implemented. We believe it is equally important to modify the AAPCC formula so as to reduce geographic disparity in payment rates and attract managed care to counties where this option is currently unavailable.

CONCLUSION

The Academy appreciates this opportunity to share its views on the issues of quality and consumer protections for Medicare beneficiaries enrolled in managed care plans. As the utilization of this option grows, family physicians expect to be even more actively involved in serving this population and participating in the development and implementation of quality measures and policies to protect HMO enrollees. The Academy would welcome the opportunity to work cooperatively with sub-committee members and staff to formulate policies addressing the quality of care and the protection of consumer interests in connection with Medicare HMO services. Thank you.

Statement of American Health Quality Association

CONSUMER PROTECTIONS AND QUALITY STANDARDS FOR MEDICARE BENEFICIARIES

The American Health Quality Association appreciates the opportunity to submit this testimony for the record. AHQA is the national, not-for-profit association representing all quality improvement organizations QIOs (formerly referred to as peer review organizations).

QIOs are community-based organizations that promote health care quality in all settings. QIOs improve the care provided to Medicare beneficiaries by monitoring health care patterns, identifying opportunities for improvement, interpreting and sharing information about care processes, health outcomes, and current science. For their Medicare work, QIOs hold three-year contracts with the HCFA to evaluate the quality of care delivered to Medicare beneficiaries. They are serving all 50 states, the District of Columbia, and the U.S. Territories. QIOs also monitor quality and promote improvements in the Medicaid program and across the private sector.

This testimony will: (1) outline our policy recommendations for a comprehensive quality evaluation and improvement program for Medicare HMOs; (2) describe the QIOs role in consumer empowerment and protection, and, (3) discuss HEDIS 3.0 and CAHPS.

A COMPREHENSIVE QUALITY EVALUATION AND IMPROVEMENT PROGRAM

Over ten percent of the nation's Medicare population is enrolled in managed care plans and Medicare enrollment in managed care plans has doubled in the past three years. Since the beginning of 1996, beneficiaries enrollment in Medicare risk plans increased at a rate of approximately 100,000 per month, and this dramatic rate of increase shows no sign of abating. Nationally, 74 percent of Medicare beneficiaries have a choice of two or more plans. While managed care enrollment varies greatly depending on geographic region, a majority of enrolled beneficiaries live in California, Florida, Oregon, New York, Arizona, and Hawaii.¹

Internal Quality Evaluation and Improvement System

As a basic principle, managed care health plans are responsible for ensuring and improving the quality of health care delivery to, and the health care outcomes of, their enrolled populations. To accomplish this, managed care health plans establish internal comprehensive quality evaluation and improvement systems that address plan performance, including the delivery and outcomes of care.

Currently, Medicare risk contracting health maintenance organizations and competitive medical plans (HMOs/CMPs) are required to have an internal quality assessment and improvement program.

An internal quality evaluation and improvement program consists of the following parts:

- an ongoing program evidenced by a written plan describing the structure, responsibilities, types of activities, and specific quality improvement projects for the coming year;
- an approach that stresses health outcomes, covering the entire range of care provided, and that examines the effects of provider compensation and incentive arrangements to ensure that appropriate services are in fact provided;
- a systematic iterative process to identify problems and areas for improvement by making appropriate changes, and monitor changes over time for effectiveness;
- peer review by physicians and other health professionals of the processes of clinical care;
- systematic data collection of performance and patient outcomes, and interpretation and feedback of these data to practitioners; and,
- written procedures for taking appropriate action to change areas needing improvement, and a process to determine overall effectiveness of the program and individual action plans.²

External Quality Evaluation and Improvement System

¹ Health Care Financing Administration Planning Conference, Discussion Questions and Context Paper, May 14, 1996, pp. 15-16.

² Armstead, Rodney C., M.D., Elstein, Paul, Ph.D, and Gorman, John. "Toward a 21st Century Quality Measurement System for Managed-Care Organizations." *Health Care Financing Review*, Summer 1995, Vol. 16, No. 4, pp. 25-37.

Internal quality evaluation systems are both necessary and important, but by themselves are incomplete and insufficient to meet the critical public need for assurance of high quality health care. Public accountability demands that internal health plan quality evaluation and improvement systems be complemented by a dependable, reliable information system and an external analysis and verification system.

External quality assurance evaluation exists at different levels to meet a variety of needs. For example, organizations such as the Joint Commission of the Accreditation of Healthcare Organizations and the National Committee on Quality Assurance guarantee a standard of the health care facility's infrastructure. The QIOs are providing the opportunity to continuously improve care and advance individual responsibility by facilitating choice.

We envision external evaluation acting on three levels.

- The first level of external quality evaluation is state licensing, federal certification, and voluntary accreditation. These processes assure that the most basic structural aspects of quality—such as proper credentialing of professionals—and minimum standards for operating health care facilities are met. Licensing, certification and accreditation provide a level playing field and some degree of uniformity across all plan operations.

- The second level involves an active, independent, community-based quality improvement organization whose work goes beyond structure and process examinations of the first level to assess and to help improve health care outcomes. Functions of such a program should include data collection and analysis, feedback of clinical performance information, and, development of measures and initiatives that lead to collaborative improvements in access and in the quality of care provided by plans to enrollees and the surrounding community. The following chapter—The Health Care Quality Improvement Program—briefly describes the current work of QIOs in this regard.

- The third and final level of an external quality evaluation program is a public information and reporting system. Such an information system is important for impartial and public reporting on health plan services, prices and performance in ways that will help both group purchasers and individual consumers in the selection of health plans, and stimulates fair and honest competition based on quality as well as cost.

THE HEALTH CARE QUALITY IMPROVEMENT PROGRAM

Right now, QIOs are leading collaborative improvement projects with risk-contracts (i.e., managed care plans). Quality improvement efforts in managed care follow the same principles as in the fee-for-service environment, with the QIO and the plan jointly entering into quality improvement activities. Unlike voluntary accreditation, the QIOs' work goes beyond reviewing structures and processes of individual plans. In their managed care work, QIOs bring together managed care plans to discuss ways to improve clinical processes, community health status, and access to care. For example, rather than just obtaining the rate of enrollees in one risk-contract who were evaluated for preventive care guidelines, QIOs look at the rates across the plans and to identify opportunities to improve the quality of care delivered in the community.

QIOs conducting quality improvement activities under the direction of HCFA are focusing on health care services of particular importance to Medicare beneficiaries: the provision of preventive care, such as influenza and pneumonia immunization and utilization of mammography; and improvement in care processes, such as hypertension, treatment of heart disease, and diabetes.

Diabetes was chosen as the major focus of improvement activities in states with the largest managed care risk populations because of the significant frequency of this condition among the Medicare population and the high correlation between the illness and the use of hospital services, as well as the known effectiveness of appropriate disease management efforts. Working with managed care plans and their physicians on improving care management, and reaching out to Medicare beneficiaries and educating them about their disease, QIOs have made considerable strides in improving care and health status of managed care populations.

Managed care organizations derive many benefits from working with their QIO and other plans. Among them are sharing of data and processes, benchmarking performance and continually improve their care delivery and save money.

EMPOWERING CONSUMERS

An important goal for the QIO program is to communicate with beneficiaries to promote informed health choices. To that end, QIOs are making information available to beneficiaries on health promotion, treatment options, and disease prevention.

For example, although many Medicare beneficiaries are aware that the flu shot prevents illness, only about a third of all eligible persons obtain the shot. Both flu and pneumonia vaccinations are a covered Medicare benefit at no cost to the beneficiary. Individuals who are not vaccinated face increased risk of illness resulting in hospitalization and perhaps unnecessary cost to the system. Every flu season, QIOs mount aggressive consumer information campaigns. For example, recent reports have indicated up to 20% increases in vaccination rates as a result of QIO interventions.

Another compelling example is screening mammography. Breast cancer is the most common cancer in women in the United States. Despite strong scientific evidence supporting the effectiveness of screening mammography and the universal recommendation that women 50 years and older undergo routine screening, studies have shown that only about one-third of older women comply. In fact, in some states that rate is even lower. Since early detection of breast cancer can save lives and obviate the need for the disfiguring surgical procedures, QIOs aggressively promote public campaigns to educate women of the benefit of screening mammography. For example, following a massive QIO-initiated educational mailing effort to 12,000 Medicare beneficiaries in one state, the QIO noted an increase in mammography rate of 27%.

PROTECTING CONSUMERS

While QIOs have undergone a reformation in their approach to quality evaluation and improvement for the purposes of protecting beneficiaries and improving quality of care, there remain ongoing concerns with access to and appropriateness of medical care delivered. Access to care is of particular concern to Medicare's elderly and disabled in the rapid transformation to managed care.

Various mechanisms are in place through which QIOs work to protect consumers, the most prominent of which are the beneficiaries' appeals and complaint rights. In each case, the QIO determines whether services provided were medically necessary and appropriate; were furnished in the appropriate care setting; Medicare coverage policies were followed and correctly billed by the provider; and, whether the care conformed to acceptable standards of quality.

Beneficiary Complaints

Medicare beneficiaries or their families who are concerned or dissatisfied about the quality of care they received, or were denied access to services or treatment by a managed care plan. QIOs investigate the complaint and determine whether the care and services meet accepted standards of care.

For example, Medicare beneficiaries enrolled in HMOs in a state with a large Medicare population now have greater access to cataract surgery. Recently, a QIO began a statewide quality improvement project focused on cataract surgery.

A beneficiary had called the QIO to complain that his HMO denied him cataract surgery. When the QIO reviewed the health plan's pre-certification criteria, it found that it was radically different from criteria used in the fee-for-service sector and from the accepted AHCPR practice guidelines on cataract surgery.

Specifically, the HMO developed indications for cataract surgery based on a patient's visual acuity level were substantially different from the AHCPR guideline recommendation. The QIO notified the HMO of the discrepancy, and the HMO adopted the AHCPR guideline. Taking it a step further, the QIO requested cataract surgery criteria from all the Medicare HMOs in the state, and discovered similar problems. To date, three HMOs covering over 250,000 Medicare beneficiaries have changed their criteria to conform to the accepted guidelines.

Beneficiary Appeals

The beneficiary may appeal when the managed care plan wants the attending physician and the hospital to discharge the patient and the patient does not agree. While many of these issues are easily resolved by the QIO in cooperation with the plan, the hospital and physician, there have been instances of potential harm or risk to the patient, warranting the QIO's intervention.

The beneficiary may also appeal any decision made by the QIO and if dissatisfied with the appeal, may present his case to an administrative law judge.

HEDIS 3.0 AND CAHPS

AHQAs applauds HCFA's recent decision to require Medicare managed care plans to (1) report on performance measures from the Health Plan Employer Data Set relevant to the Medicare managed care population and, (2) to participate in an inde-

pendently administered Medicare beneficiary satisfaction survey, the Medicare version of the Consumer Assessments of Health Plans Study (CAHPS).

The information that will be collected and disseminated through these quality assessment tools—HEDIS and CAHPS—will ultimately empower beneficiaries to choose among health plans and contribute to improved health care through identification of opportunities to improve the medical care delivered by plans. In addition, the data gathered will provide the QIOs relevant useful information for monitoring quality of and access to care provided by the plans.

HCFA recently announced plans to employ the QIO industry in the external validation of HEDIS measures. Working in concert with HCFA and NCQA, select QIOs will be responsible for: 1) designing a Medicare HEDIS data collection training package for all Medicare-participating HMOs; (2) conducting training for HMOs; (3) providing ongoing technical support to all plans as needed; (4) developing audit protocols and training packages and training auditors; and, (5) conducting audits of health plans submitted data.

The results of the data will be utilized by HCFA to make purchasing decisions and by QIOs to facilitate ongoing improvement activities with health plans across the country.

CONCLUSION

With the ever increasing numbers of Medicare beneficiaries enrolling in managed care plans, the need for quality evaluation and improvement mechanisms will likewise increase. The competition between managed care plans, apparent in the many full-page ads appearing in newspapers throughout the country, will no doubt continue. It is our belief that competition ought to be based on a plan's ability to bring additional benefits for lower costs. The level of quality of care provided by managed care plans should be assumed and ever improving with the QIOs continued involvement.

The presence of unbiased professional organizations with the resources and dedication evidenced by QIOs will become even more essential.

The American Health Quality Association looks forward to working with the Congress on designing strategies for improving the quality of health care for Medicare beneficiaries and all Americans.

Statement of American Society of Internal Medicine

INTRODUCTION

The American Society of Internal Medicine (ASIM) represents physicians who specialize in internal medicine, the nation's largest medical specialty. Internists provide care to more Medicare patients than any other specialty. With the rapid growth in beneficiary enrollment in Medicare managed care, internists increasingly are providing services to their patients through arrangements with Medicare HMOs and other managed care arrangements.

ASIM believes there is a need for Congress and the administration to make improvements in the standards used to evaluate Medicare managed care organizations (MCOs). The federal government must implement revised standards to assure that beneficiaries are given the information they need to make an informed choice of health plan, that beneficiaries receive reasonable assurances that they will have access to the physicians and services that they need, and that requests for reconsideration of denied claims are heard in a timely manner.

INCREASED ENROLLMENT REQUIRES INCREASED OVERSIGHT

In recent years, the enrollment of Medicare beneficiaries in health maintenance organizations (HMOs) and competitive medical plans (CMPs) has grown rapidly. Currently, approximately 14 percent of beneficiaries belong to a Medicare managed care plan. The CBO projects that the share of total Medicare outlays that goes to HMOs and other Medicare managed arrangements will increase from 9.4% in FY 1996 to 32.9% in FY 2007—even without enactment of additional incentives for beneficiaries to enroll in managed care.

With increased enrollment, there is an increased need for the federal government to exercise appropriate oversight over the care provided to Medicare beneficiaries who are enrolled in MCOs. Recent reports from the Institute of Medicine, the General Accounting Office (GAO), and the PPRC all support the need for improved standards for health plans that contract with Medicare. In its 1996 report to Congress, the PPRC recommended that all health plans that contract to provide services to Medicare beneficiaries meet standards relating to quality, access, disclosure of information and due process. The GAO, in a recent report titled "HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance" supports ASIM's views that HCFA needs to do more to implement measures that will enable beneficiaries to make an informed choice of plan. The GAO concluded that HCFA can readily provide indicators of beneficiary satisfaction and other plan-specific information, including statistics on beneficiary disenrollments and complaints, medical loss ratios (the percentage of HMO revenues spent on medical care) and other financial data, and visit monitoring results. The percentage of claims that are appealed to HCFA, and then reversed or upheld upon appeal, is another indicator of HMO performance that can immediately be made available to beneficiaries.

Although HCFA plans to require a standardized beneficiary satisfaction survey "beginning with the upcoming calendar year," the GAO expressed concern that HCFA has no plans to provide this information automatically to beneficiaries, and that the comparison chart that HCFA plans to develop will be available only through the Internet—a forum that may not be easily accessible to most Medicare beneficiaries. We agree with the GAO's conclusion that HCFA should provide comparative information on each plan directly to beneficiaries.

ASIM'S RECOMMENDATIONS

In August 1996, ASIM released a policy paper titled "Re-Inventing Medicare Managed Care: Improving Choice, Access and Quality." The paper presents a detailed and comprehensive set of proposals for improving the comparative information that is available to beneficiaries; for assuring adequate access to physicians and other needed services, especially for patients with special needs; for streamlining and improving the appeals process; for incorporating risk adjustments into the payments to HMOs; for expanding the types of plans available to beneficiaries; for assuring adequate physician and patient involvement in developing health plan standards and protocols; for external oversight of HMO quality; and for providing due process for physicians who are "de-selected" by a plan. We would be pleased to provide the entire paper to the subcommittee.

At a minimum, ASIM urges the subcommittee to report legislation that would:

1. Direct the Secretary to mandate that Medicare MCOs disclose to current and prospective enrollees and providers information needed to make an informed choice of plans, including:

A. Requirements that limit access to services (i.e. extent to which enrollees may select the provider of their choice, restrictions that limit coverage to prescription drugs approved by the MCO, and rules that limit access to laboratory tests in physicians' offices);

B. Indicators of health plan quality, access, and patient satisfaction (including disenrollment rates; number and percentage of claims that were denied and then reversed upon appeal to the Secretary; the MCO's medical loss ratio—defined as the proportion of total revenue spent on medical care, as opposed to administrative expenses or funds retained or distributed to owners; and the results of standardized patient satisfaction surveys).

In the report cited above, the GAO found that beneficiaries often are unaware of the restrictions on access to certain services that are typically required by MCOs. Disclosure of such restrictions will enable beneficiaries to make a more informed choice of plans, and will reduce subsequent misunderstandings and dissatisfaction. Information on disenrollment rates, claims denials, and medical loss ratios can be useful indicators of the quality of care rendered with a plan. HCFA has begun to provide beneficiaries with more information but its efforts to date fall short of providing the kinds of information discussed above.

2. Mandate that Medicare MCOs review preauthorization requests for urgent care services within one hour and all other preauthorization requests within 24 hours. Direct the Secretary to streamline the appeals process for denials by Medicare MCOs by reducing by half the days that MCOs are allowed to consider an appeal of an initial denial.

Although the administration has stated that it intends to make changes in the appeals process to provide more timely determinations on denials of care by Medicare MCOs, it is our understanding that the administration's proposal will not go far enough in assuring timely rulings on preauthorization requests, and in reducing the amount of time that MCOs have to rule on appeals of initial denials. According to the GAO and the PPRC, MCOs are currently given up to 60 days to make their initial determination. They have another 60 days to decide on an appeal of the initial determination—a total of four months when patients are effectively being denied access to care that they and their physician believe to be necessary. Cases that require HCFA review can take even longer—sometimes up to 270 days. Further, GAO found that MCOs and HCFA's own contractor often failed to meet the current deadlines for review and reconsideration of denied claims, but HCFA has been unwilling to take action against MCOs or the contractor for failing to process reviews and reconsideration in a timely manner. In the meantime, beneficiaries are the ones hurt by the failure to get a timely answer to their request that payment be authorized for medical services that they and their physicians believe to be appropriate.

We understand that HCFA is now under a court order to make specific improvements in the appeals process. ASIM is pleased by this decision, particularly the requirement that HCFA assure that plans do not retaliate against physicians who help enrollees appeal a denial by a Medicare managed care plan. HCFA has not yet indicated if the decision will be appealed. ASIM believes that it would be helpful for Congress to step in and provide specific legislative direction on improvements in the appeals and grievance processes.

3. Mandate that Medicare MCOs establish mechanisms to incorporate the recommendations, suggestions and views of enrollees and participating physicians into the medical policies, medical management, utilization review, and quality and credentialing policies and criteria developed by the MCO.

Physician involvement in establishing managed care policies that have a direct impact on clinical decision-making is essential if patients are to have confidence in their HMO. Rather than attempting to legislate the lengths-of-stay for given procedures, it would be far better to mandate a process that would assure that managed care plans do not adopt restrictions on coverage that lack the support of the physicians who are ultimately responsible for patient care.

4. Mandate that HCFA immediately incorporate risk adjustments into payments to HMOs.

The President's budget proposes that the average adjusted per capita cost (AAPCC) be reformed by (1) setting local rates at 90 percent of the prevailing fee-for-service rates, rather than 95 percent under current policy (2) subtracting graduate medical education payments and disproportionate share hospital payments from the AAPCC and instead giving them directly to the institutions incurring the costs and (3) lowering the AAPCC in certain high cost areas and increasing them in low cost areas.

ASIM has no specific policy on the proposal to lower payments from 95 percent to 90 percent of the prevailing fee-for-service rates. Given that the CBO projects that outlays on Medicare HMOs will increase at an average rate of 71 percent per annum, it is reasonable for the Congress and the administration to review ways to achieve savings in this category of spending, especially if this will reduce the need to further slash fee-for-service payments. Although not conclusive, there are some studies that suggest that Medicare HMOs do enroll a healthier patient population than the fee-for-service program, and that the current formula may on average over-compensate HMOs for the care of the healthier patients that they typically enroll. ASIM also supports the goal of reducing geographic inequities in AAPCC payments, but we have not yet determined if the administration's proposal is the best way to correct such inequities.

ASIM is concerned that in the absence of a risk adjustment for the AAPCC payments to HMOs, HMOs that treat a sicker mix of patients will be penalized, especially if the AAPCC rate is lowered to 90 percent from 95 percent. This would increase the disincentive for HMOs to enroll sicker patients. ASIM supports the PPRC's view that: regardless of how payment rates are set, as long as Medicare beneficiaries can choose among options, improved risk adjustment will be essential. Otherwise, health plans will not be fairly paid for enrollees with better or worse-than-average status (for example those with chronic conditions or functional disability). Without improvements in risk adjustment, plans will continue to have an incentive to avoid enrolling patients who will be expensive to care for. The commission recommends that improved risk adjustment be implemented immediately. (Statement before the Subcommittee on Health, Ways and Means, on Medicare HMO Payment Policy, February 25, 1997)

Because internists tend to treat Medicare patients that are older and sicker than those of other physicians, ASIM believes that it is particularly important that Congress initiate payment reforms—including risk adjustment—for Medicare HMOs that would decrease the likelihood that internists' patients will be discriminated against by HMOs that are trying to limit their own risk.

5. Mandate the HCFA require that plans adopt a "prudent layperson" standard in making coverage decisions on emergency room denials.

Beneficiaries should not be financially penalized for seeking initial treatment in an emergency room when they have a reasonable basis to believe that they had a medical emergency, even if it is later determined that the condition was not life-threatening. ASIM supports H.R. 815, introduced by Reps. Ben Cardin and Marge Roukema and co-sponsored by several members of this subcommittee, including Reps. Stark, Levin, and McDermott, which would apply a "prudent layperson" standard not only to Medicare HMOs, but also to all group health plans and health insurance coverage.

CONCLUSION

ASIM supports major reforms in Medicare that would move the program toward a defined contribution model, similar to the Federal Employees Health Benefit Program. A defined contribution program would have to include major safeguards to protect beneficiaries, however, including defined minimum standards to hold all competing plans accountable for the quality of care, access to needed services, and physician and patient involvement in coverage standards and utilization review protocols. The defined contribution would have to be adequate to allow beneficiaries to choose from a wide range of plans that offer benefits at least equal to the current program.

Even in the absence of major restructuring along these lines, however, it is clear that the federal government can and should do a better job of holding Medicare HMOs and other managed care plans accountable to reasonable quality standards. The recommendations presented in this statement, and the more comprehensive set of proposals in our "Re-Inventing Medicare Managed Care" policy paper, would assure that the federal government exercises sufficient oversight over decisions by health plans that can affect quality and access, without stymying innovation and market competition.

ASIM looks forward to working with the subcommittee on enacting appropriate quality and access standards for all Medicare managed care plans.

Statement of the Patient Access to Specialty Care Coalition

Mr. Chairman: This statement is made on behalf of the Patient Access to Specialty Care Coalition (Coalition), consisting of 128 patient, physician, non-physician, health care professional, and senior citizen organizations dedicated to ensuring access to specialists, choice of health care professional, and basic patient protections in this changing health care marketplace.

The Coalition was formed in 1993 in response to President Clinton's comprehensive health care reform proposal. Throughout the last four years, the Coalition has been committed to ensuring that the highest quality health care is maintained no matter what structures are developed for providing this care.

The Coalition has not deviated from its choice and access principles, which include access to specialists in-network, the availability of out-of-network care, a timely appeals process, a ban on financial incentives which result in the withholding of care or the denial of a referral, a consumer information checklist to provide the broadest information to patients, and a prohibition on "gag clauses."

It is the Coalition's firm belief that if these principles are incorporated into Federal legislation, they will go a long way to protect patients in this rapidly changing health care environment, and ensure that they get the highest quality health care they deserve. Contrary to reports in the press, these principles are not "anti-managed care," and the Coalition is not trying to derail or change any mechanism being developed in the marketplace to deliver health care. In fact, the Coalition recognizes that several managed care plans in the country provide quality health care to their patients and embrace these principles. However, there are also many health care plans that do not.

Therefore, for more than four years, the Patient Access to Specialty Care Coalition has been advocating that several simple, nonintrusive steps be taken to ensure that patients receive adequate care in a managed care setting.

For more than four years, the health care insurance industry has denied that there are any problem areas at all that need to be addressed—either by themselves or through Federal and/or State legislation.

In the last few years, court case after court case, both State and Federal have confirmed the Coalition's concerns about these problems, and have, in fact, proven the industry's assertion to be wrong. Because Congress has not yet been able to address these areas, several States have begun to pass laws of their own to address these real patient concerns. Also, with no "global" approach to this matter, Congress is now witnessing the introduction of several bills addressing specific procedures or conditions.

At present, as the public outcry has become so loud, the industry has responded by proposing certain voluntary standards to address "problems" that they have for so long denied as even existing. While these voluntary standards are a step in the right direction, they fall far short of what is needed to ensure patients receive timely access to quality care in a managed care environment.

The Coalition has been a strong advocate of applying its principles to all health care plans and providers. However, in the past, there has not been widespread support in Congress for any comprehensive approach to health care delivery. Also, there has been a concern about "too much regulation" or interference in the marketplace. Consequently, most recently, the Coalition has concentrated its efforts on applying these principles to the Medicare program.

Inasmuch as the Federal government is paying for the health care received by Medicare enrollees, it is fiscally responsible for the government to determine that it is getting value for its payments to managed care plans.

Therefore, in this 105th Congress, the Coalition has strongly endorsed H.R. 66, the Medicare Patient Choice and Access Act of 1997. This legislation currently has 43 cosponsors—both Democrats and Republicans—and is a modest approach for providing needed protections for patients participating in the Medicare program. All of these Medicare provisions are entirely budget neutral, and some have already been scored as such by the Congressional Budget Office.

ASSURING ADEQUATE IN-NETWORK ACCESS

Current Federal law (Paragraph 4 of Subsection (c) of Section 1876 of the Social Security Act) already requires that managed care health plans provide access to the full range of Medicare health care benefits. The provisions of H.R. 66 clarify these provisions and contain more specificity about the care which must be provided.

OUT-OF-NETWORK ACCESS

The provisions of H.R. 66 require that if, at the time of enrollment, a managed care (closed-panel) plan is offered to a Medicare enrollee, a point-of-service plan must also be offered which allows the patient to go out-of-network.

As Congress explores the role of managed care in controlling health care costs, it also has the opportunity to give Medicare enrollees more choices, and more security in knowing that the health care provider of their own choice can always be there if they choose a point-of-service plan. If Congress is committed to moving more seniors into managed care plans, it makes sense to increase the comfort-level of the elderly by having point-of-service plans available when offering a managed care product.

In addition, making out-of-network treatment available to Medicare enrollees is a very good quality assurance check. If too many Medicare enrollees in a plan are going outside of the plan to seek care, this is an early warning signal to the Health Care Financing Administration that there is something wrong with the managed care plan.

The provisions of H.R. 66 do not require any copayment amounts or place any requirements on what type of plans must be provided. The marketplace can decide this.

Allowing the option of point-of-service at the time of enrollment does not affect the health care plans' ability to be aggressive in their cost containment activities, nor does it limit their efforts to encourage providers and consumers to use health care resources wisely. It will simply put pressure on health plans to keep the patient's welfare uppermost on their agenda, ahead of dividends and the bottom line.

The health insurance industry has consistently claimed that a point-of-service feature would greatly increase the cost of doing business. This is not true. The Coalition previously has shared with your Subcommittee the 1995 Milliman and Robertson Actuarial Analysis which demonstrated that a point-of-service feature can actually save a health care plan money. Moreover, point-of-service continues to be the fastest growing insurance product.

GRIEVANCE AND APPEALS PROCESS

Current Federal law requires that Medicare managed care beneficiaries have access to a meaningful and timely appeals process (Paragraph 5 of Subsection (c) of Section 1876 of the Social Security Act. (However, Federal Court cases, as well as an investigation by the Office of the Inspector General of the Department of Health and Human Services, have identified many instances where Medicare beneficiaries are not receiving a timely resolution of a grievance concerning a denial of care, treatment, or testing in managed care plans. The appeals process provisions of H.R. 66 are modeled after the one described by a Federal District Court Judge in Grijalva v. Shalala, 946 F.Supp. 747 (D. Ariz. 1996).

The health care insurance industry has also called for a timely resolution of disputes concerning treatment determinations. However, the problem with the industry's approach is that there are concerns raised by patients that go much further than just a determination of treatment. In the past, many disputes have dealt with the failure to order a test, or the delay in referral to a specialist. Consequently, the provisions of H.R. 66 permit the patient to seek timely review, at any time, for any actions taken or not taken by the health plan, and call for a 30 day resolution of the grievance.

NOTICE OF ENROLLEE RIGHTS AND ENROLLEE INFORMATION CHECKLIST

Current Federal law requires that managed care health plans disclose certain information about the rights and benefits to which Medicare enrollees are entitled (Paragraph (E) of Subsection (c)(3) of Section 1876 of the Social Security Act.) The provisions of H.R. 66 expand upon the information which must be provided to Medicare beneficiaries.

RESTRICTIONS ON PROVIDER INCENTIVES

Currently, Federal law places certain restrictions on financial incentives to physicians (Paragraph (8) of Subsection (1) of Section 1876 of the Social Security Act). The provisions of H.R. 66 simply expand this current law to all health care professionals and providers who receive payment under Part A and B of Medicare, not just physicians.

PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS ("GAG CLAUSES")

A few months ago, the Health Care Financing Administration sent a letter to all managed care plans participating in the Medicare program, requiring them to remove from their contracts any restrictions on the physicians' ability to discuss with the patient medical treatment options. This requirement was not instituted by regulatory action. It only applied to physicians and it took a very narrow definition of medical communications (i.e. treatment options). Recently, the American Association of Health Plans (AAHP) listed a number of communications which it considered to be appropriate to convey between the provider and the patient—but this was voluntary and only at the patient's request.

The provisions of H.R. 66 include a broad definition of medical communications, specifically taken from the AAHP's own literature, and state that all health care professionals (not just physicians) cannot be prohibited from making such communications.

Mr. Chairman, the Patient Access to Specialty Care Coalition firmly believes that the enactment into law of these six principles will help to ensure that Medicare patients continue to have real choice and access to quality health care. The Coalition's approach is simple, it is comprehensive and it places reasonable requirements on the industry.

In your continuing deliberations on the expansion of managed care in the Medicare program, and on the need for quality assurances, we urge this Subcommittee to consider H.R. 66, the Medicare Patient Choice and Access Act, as a model and comprehensive approach to address these important patient concerns.

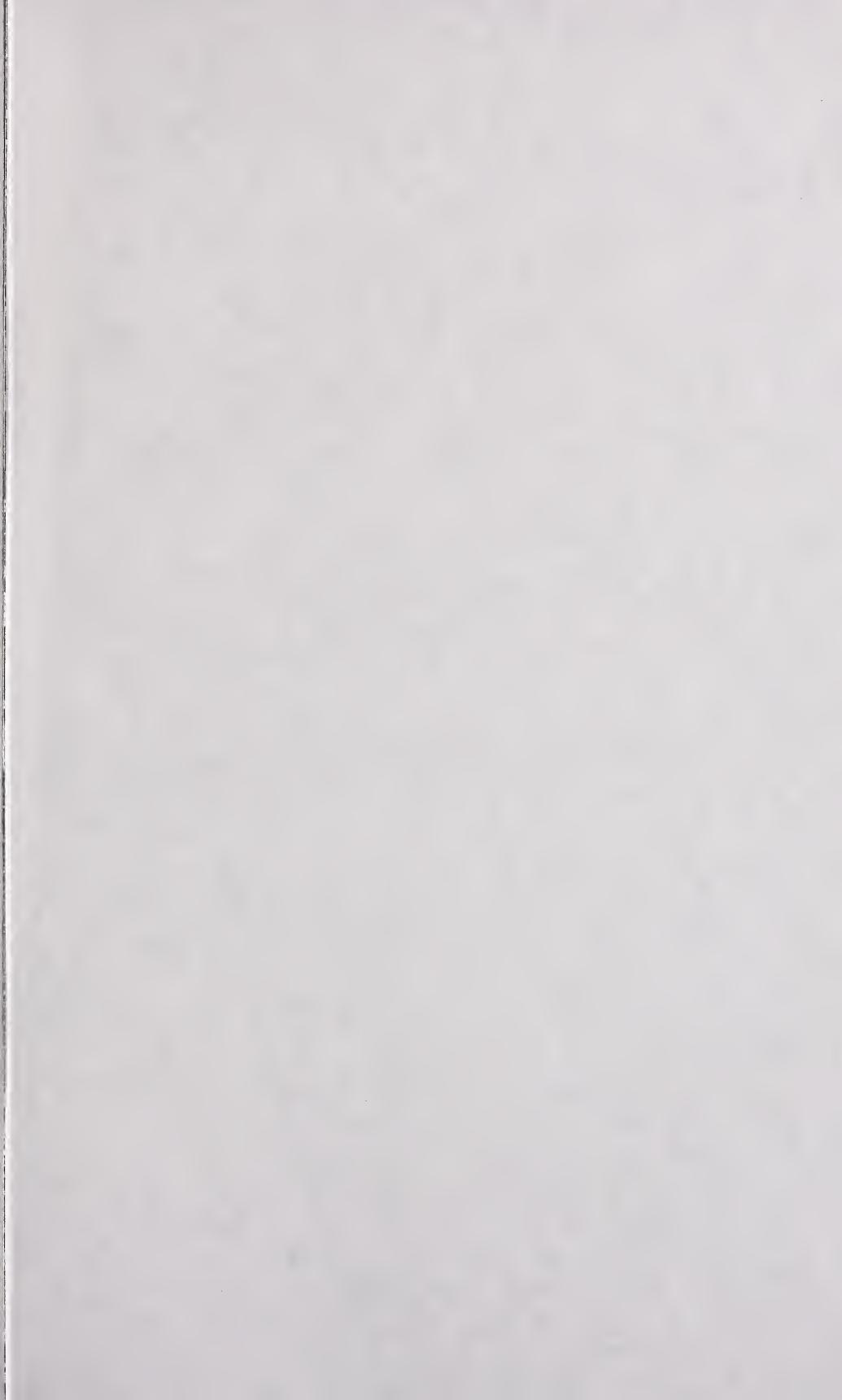
A listing of the current membership of the Patient Access to Specialty Care Coalition follows.

Membership List of the Patient Access to Specialty Care Coalition

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| Allergy and Asthma Network | American Association of Clinical Endocrinologists | American EEG Society |
| Mothers of Asthmatics, Inc. | American Association of Clinical Urologists | American Gastroenterological Association |
| American Academy of Allergy and Immunology | American Association of Hip and Knee Surgeons | American Heart Association |
| American Academy of Child and Adolescent Psychiatry | American Association of Neurological Surgeons | American Liver Foundation |
| American Academy of Dermatology | American Association of Orthopaedic Foot and Ankle Surgeons | American Lung Association |
| American Academy of Facial Plastic and Reconstructive Surgery | American Association of Private Practice Psychiatrists | American Orthopaedic Society for Sports Medicine |
| American Academy of Neurology | American College of Allergy and Immunology | American Osteopathic Academy of Orthopedics |
| American Academy of Ophthalmology | American College of Cardiology | American Osteopathic Surgeons |
| American Academy of Orthopaedic Surgeons | American College of Foot and Ankle Surgeons | American Pain Society |
| American Academy of Otolaryngology-Head and Neck Surgery | American College of Gastroenterology | American Podiatric Medical Association |
| American Academy of Pain Medicine | American College of Nuclear Physicians | American Psychiatric Association |
| American Academy of Physical Medicine & Rehabilitation | American College of Osteopathic Surgeons | American Psychological Association |
| American Association for Hand Surgery | American College of Radiation Oncology | American Rehabilitation Association |
| American Association for Holistic Health | American College of Radiology | American Sleep Disorders Association |
| American Association for the Study of Headache | American College of Rheumatology | American Society for Dermatologic Surgery |
| | American Diabetes Association | American Society for Gastrointestinal Endoscopy |
| | | American Society for Surgery of the Hand |

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| American Society for Therapeutic Radiology and Oncology | California Access to Specialty Care Coalition | National Rehabilitation Hospital |
| American Society of Anesthesiologists | California Congress of Dermatological Societies | National Right To Life Committee |
| American Society of Cataract and Refractive Surgery | College of American Pathologists | North American Society of Pacing and Electrophysiology |
| American Society of Clinical Pathologists | Congress of Neurological Surgeons | Oregon Dermatology Society |
| American Society of Colon and Rectal Surgery | Cooley's Anemia Foundation | Orthopaedic Trauma Association |
| American Society of Dermatology | Cystic Fibrosis Foundation | Outpatient Ophthalmic Surgery Society |
| American Society of Echocardiography | Diagenetics | Patient Advocates for Skin Disease Research |
| American Society of Foot and Ankle Surgeons | Digestive Disease National Coalition | Pediatric Orthopaedic Society of North America |
| American Society of General Surgeons | Epilepsy Foundation of America | Pediatrix Medical Group: Neonatology and Pediatric Intensive Care Specialists |
| American Society of Hematology | Eye Bank Association of America | Pituitary Tumor Network |
| American Society of Nephrology | Federated Ambulatory Surgery Association | Renal Physicians Association |
| American Society of Pediatric Nephrology | Gullain-Barre Syndrome Foundation | Scoliosis Research Society |
| American Society of Plastic and Reconstructive Surgeons, Inc. | Huntington's Disease Society | Sjogren's Syndrome Foundation Inc. |
| American Society of Transplant Physicians | Infectious Diseases Society of America | Society for Vascular Surgery |
| American Society of Transplant Surgeons | Joint Council of Allergy and Immunology | Society of Cardiovascular & Interventional Radiology |
| American Society of Surgeons | Lupus Foundation of America, Inc. | Society of Critical Care Medicine |
| American Thoracic Society | National Association for the Advancement of Orthotics and Prosthetics | Society of Gynecologic Oncologists |
| American Urological Association | National Association of Epilepsy Centers | Society of Nuclear Medicine |
| Amputee Coalition of America | National Association of Medical Directors of Respiratory Care | Society of Surgical Oncology |
| Arthritis Foundation | National Committee to Preserve Social Security and Medicare | Society of Thoracic Surgeons |
| Arthroscopy Association of North America | National Foundation for Ectodermal Dysplasias | The Alexander Graham Bell Association for the Deaf, Inc. |
| Association of American Cancer Institutes | National Hemophilia Foundation | The American Society of Dermatopathology |
| Association of American Medical Colleges | National Kidney Foundation | The Endocrine Society |
| Association of Freestanding Radiation Oncology Centers | National Multiple Sclerosis Society | The Paget Foundation For Paget's Disease of Bone and Related Disorders |
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